

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, in its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN TB D.O.A d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN Hospital												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON d. STREET ADDRESS 2322 BLUERIDGE AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) CHARLES BARNES ABBOTT JR.												4. DATE OF DEATH AUGUST 20 1961																							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1897		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country) MARYLAND						12. CITIZEN OF WHAT COUNTRY? U.S.A																	
13. FATHER'S NAME CHARLES BARNES ABBOTT SR.												14. MOTHER'S MAIDEN NAME CARRIE RUSSELL																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES												16. SOCIAL SECURITY NO. 578-03-8912												17. INFORMANT Wife Eliz. Jane Abbott (Same as above)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) 420.1												INTERVAL BETWEEN ONSET AND DEATH Sudden																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																			
ACTUAL SIGNATURE Frank J. Brochart												M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>																							
EXAMINER'S NAME (Type) FRANK J. BROCHART												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																							
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
												Address (Street, city, town, or county)																							
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial 8/23/61												22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington County Virginia																							
23. FUNERAL DIRECTOR Raymond A. Ziska												24a. REC'D BY REGISTRAR AUG 25 '61																							
Address 8434 Georgia Avenue Silver Spring, Maryland												24b. REGISTRAR'S SIGNATURE Arthur L. Kraus																							

200-100



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9233

CERTIFICATE OF DEATH

09223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>4704 Morgan Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Thomas S Adams</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>19 61</u>		5. SEX <u>Male</u>							
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 24, 1902</u>							
9. AGE (In years last birthday) <u>58</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Louisiana</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Dr. Thomas S. Adams</u>		14. MOTHER'S MAIDEN NAME <u>Helen Wilkins</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>429-09-8079</u>		17. INFORMANT <u>Mrs. Amanda Adams</u> Address <u>As above</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While el work <input type="checkbox"/> Not While el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____							
20f. (City or town) _____		20g. (County) _____		20h. (State) _____							
21. I certify that (I) (his hospital) attended the deceased from <u>AUG. 17, 1961</u> , to <u>AUG. 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>AUG. 28, 1961</u> , and that death occurred at <u>5:09</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Leo M. Curtis</u>				22b. DATE SIGNED <u>8-28-61</u>							
22c. PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>				22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Trans 9/1/61</u>		23b. DATE THEREOF <u>9/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Roselawn Cemetery</u>							
23d. LOCATION (City, town or county) <u>Baton Rouge, Louisiana</u>		23e. (State) <u>Louisiana</u>		23f. REGISTRAR'S SIGNATURE <u>C. L. S. Frank</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. ADDRESS <u>Bethesda, Maryland</u>		25. RECD BY REGISTRAR <u>AUG 30 61</u>							

MEDICAL CERTIFICATION

1933

1933

8

Robert A. Murphy
Residence 1011
1011
1011

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9234

CERTIFICATE OF DEATH

09224

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>52 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>2024 Powhatan Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Raymond Marlowe Ager</u>				4. DATE OF DEATH <u>August 8 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 23, 1886</u>		9. AGE (In years) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Charles B. Ager</u>			14. MOTHER'S MAIDEN NAME <u>India Marlowe</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-307540</u>		17. INFORMANT <u>J. Norman Ager - 6100 Ager Road, Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 420 <input checked="" type="checkbox"/> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute myocardial infarct</u> (a), stating the underlying cause last. (c) <u>Coronary atherosclerosis</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>2 hrs</u> <u>Several years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 9, 1961</u> to <u>JULY 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 7, 1961</u> and that death occurred at <u>4:08 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond O. West</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>				22d. ADDRESS <u>WASHINGTON SANITARIUM</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Aug. 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Thomas</u>				25a. REC'D BY REGISTRAR <u>Aug 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

Montgomery

Town Park

Maryland

24 miles Hattsville

Prince George's

Washington Suburban Highway 204 Potomac Road

Raymond - Malone Ager

August 8

Male white

December 23, 1882

Former

Charles B. Ager

India Malone

Washington, D.C.

N. 2 A.

Woman Ager - 6100 Ager Road, Md.

Washington, D.C.

Washington, D.C.

Washington, D.C.

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Washington, D.C.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9235

CERTIFICATE OF DEATH

09225

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 63 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney d. STREET ADDRESS P. O. Box 15 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BUSH First (none) Middle AINSWORTH Last		4. DATE OF DEATH August 30, 19 61 Month Day Year		5. SEX Male			
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 24, 1897 yrs. Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Farming-Carpentry		11. BIRTHPLACE (County & State, or foreign country) Virginia			
13. FATHER'S NAME James M. Ainsworth		14. MOTHER'S MAIDEN NAME Margaret E. Wiley		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes-NWI		16. SOCIAL SECURITY NO. 218-18-0041		17. INFORMANT The Medical Record			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Histoplasmosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 124-22 DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 1 year		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Staphylococcal Septicemia 2. Pulmonary tuberculosis; active							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) June 28, 1961, to August 30, 19 61		20g. (County) August 30, 19 61		20h. (State) 12:20 P.M.			
21. I certify that (I) (this hospital) attended the deceased from June 28, 1961, to August 30, 19 61 that (I) (we) last saw the deceased alive on August 30, 19 61, and that death occurred at 12:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE William T. Butler		22b. DATE 8/30/61		22c. PHYSICIAN'S NAME (Type) William T. Butler, M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22e. DATE SEP 5 '61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-2-61		23c. NAME OF CEMETERY OR CREMATORY Laytonsville			
23d. LOCATION (City, town or county) Laytonsville, Md.		23e. REC'D BY REGISTRAR SEP 5 '61					
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		24b. ADDRESS Laytonsville, Md.		24c. REGISTRAR'S SIGNATURE Orlino S. Knott			

08382

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(M)

Montgomery
 15 days
 The Clinical Center
 P. O. Box 15
 Maryland
 20705

20705
 February 20, 1977
 (Name)
 20705
 20705

James H. Armstrong
 20705
 The Clinical Center
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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9236

CERTIFICATE OF DEATH

09226

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 16 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 506 Gilmore Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SALLIE LEE ALLMAN		4. DATE OF DEATH Month August Day 10 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1883
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cigar Rolling Machine Operator	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Nathaniel Thomas Allman		14. MOTHER'S MAIDEN NAME Annie Wrenn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 223-10-1224	
17. INFORMANT (Wellford Harrison) nephew-9404 Corsica Dr.		Address Beth, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO (b) Coronary Thrombosis (c) Coronary atherosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 20 hours 5 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 Aug. 1961 to 10 Aug. 1961, that (I) (we) last saw the deceased alive on 10 Aug. 1961, and that death occurred at 7:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Seruch T. Kimble		22b. DATE SIGNED 10 Aug '61	
22c. PHYSICIAN'S NAME (Type) Seruch T. Kimble		22d. ADDRESS 927 Pershing Drive, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 14, 1961	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Montgomery County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC., SILVER SPRING, MD. Raymond A. Ziska		25a. REC'D BY REGISTRAR 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur J. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheaton Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2916 Northhampton St. N. W. d. STREET ADDRESS Washington, D. C.	
3. NAME OF DECEASED (Type or print) Sadie First Middle Last		4. DATE OF DEATH August 28 1961 Month Day Year	
5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 15/1886 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Russia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Trotsky, Russia		14. MOTHER'S MAIDEN NAME Rose Trotsky, Russia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 558-36-3241A 17. INFORMANT Carl J. Alster Address (see 2c & 2d)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Ca DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 1961 to AUG 28 1961 , that (I) (we) last saw the deceased alive on AUG 4 1961 , and that death occurred at 6:00 AM, from the causes and on the date stated above.			
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) BERNARD H. OSTROW		22b. DATE SIGNED 22d. ADDRESS 8107 EASTERN AVE SS MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8/30/61		23c. NAME OF CEMETERY OR CREMATORY B'nai Abraham - Zion Cem. 23d. LOCATION (City, town or county) (State) Chicago, Ill.	
24. FUNERAL DIRECTOR'S SIGNATURE Golding T. H. H. ADDRESS 4217-92 St NW		25a. REC'D BY REGISTRAR DATE AUG 29 '61 25b. REGISTRAR'S SIGNATURE Arthur S. House	

(M)

(I)

09227

47x3

14 1
FOR
HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09228

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>BOX 59</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND</u> <u>BAKER</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>9/21/34</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>26</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technical Arch.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Labor Dept.</u> 11. BIRTHPLACE (State or foreign country) <u>Rockville, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Raymond I. Baker Sr.</u> 14. MOTHER'S MAIDEN NAME <u>Grace Newman</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>218-30 2778</u> 17. INFORMANT <u>Brother Rudolph Baker (Same as above)</u> Address <u>1 Day</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Derivation of Brain Stem</u> (b) <u>Intracerebral Edema</u> (c) <u>Intra cerebral Hemorrhage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>2 days</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto involved in accident</u> 20c. TIME OF INJURY Month, Day, Year <u>10</u> p.m. <u>8-6</u> <u>1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ind R-28</u> 20f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8-9-61</u> Address (Street, city, town, or county)	
ACTUAL SIGNATURE <u>Frank J. Brochart</u> M.D. EXAMINER'S NAME (Type) <u>Frank Brochart</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8/11/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National.</u> 22d. LOCATION (City, town, or country) <u>Arlington, Va.</u> (State)	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 14 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

This form is to be used as a burial-transit permit only. It is not to be used as a death certificate. It is to be used only in cases of death occurring in the home or in a hospital, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

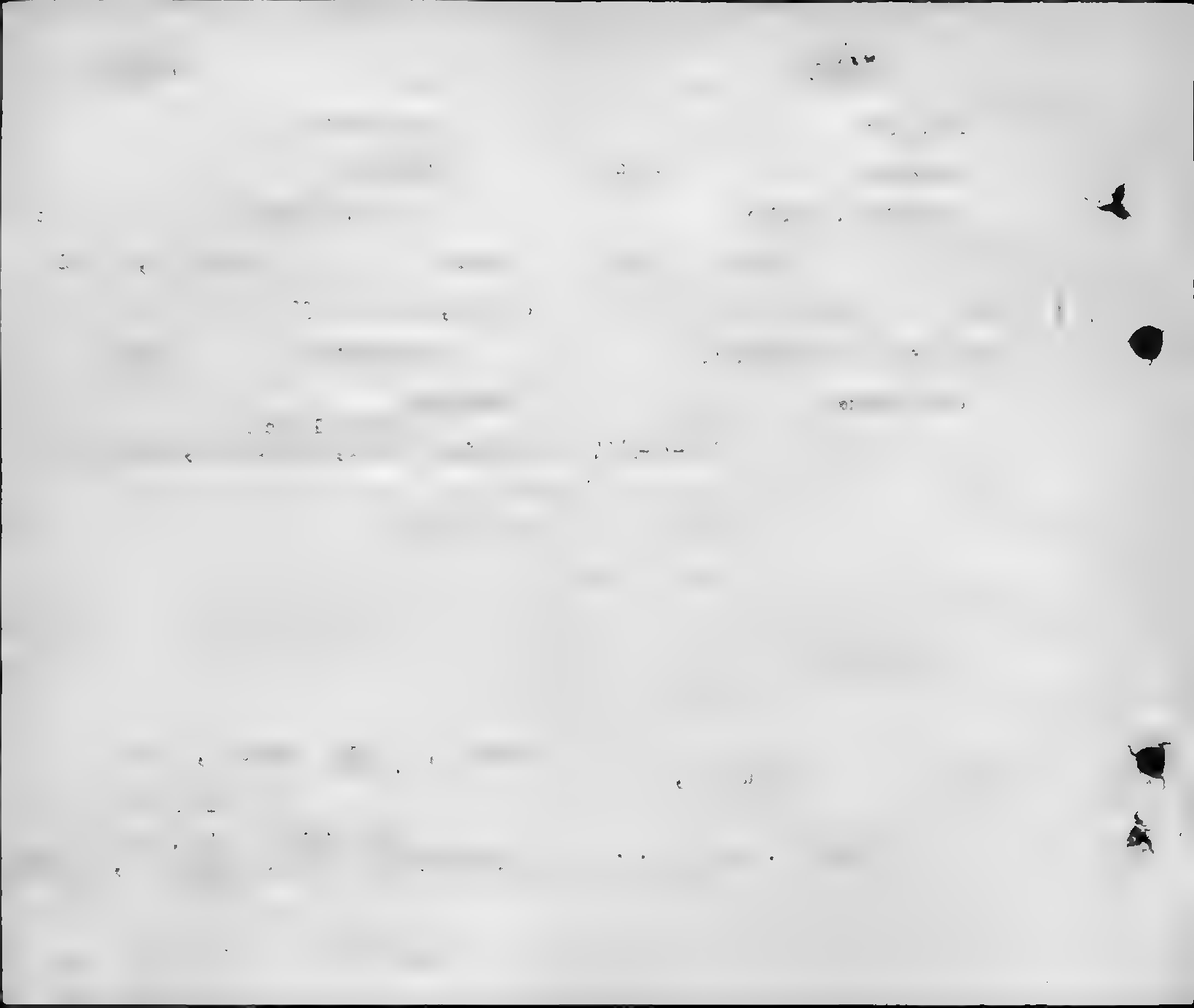
9239

09229

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN (b) 9 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Scranton c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1425 Crown Avenue d. STREET ADDRESS 1425 Crown Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First HAROLD Middle JACOB Last BARKE 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 26, 1924 9. AGE (in years last birthday) 37 yrs. IF UNDER 1 YEAR: Months 11 Days 19 10. IF UNDER 24 HRS: Hours 11 Min. 61		4. DATE OF DEATH August 11, 1961 9. AGE (in years last birthday) 37 yrs. IF UNDER 1 YEAR: Months 11 Days 19 10. IF UNDER 24 HRS: Hours 11 Min. 61 11. BIRTHPLACE (Country & State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver & Warehouseman 10b. KIND OF BUSINESS OR INDUSTRY Truck Driver & Warehouseman 11. BIRTHPLACE (Country & State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob Barke 14. MOTHER'S MAIDEN NAME Rosa Mais 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW II 16. SOCIAL SECURITY NO. 188-12-9427 17. INFORMANT The Medical Record 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Insufficiency (b) Dilatation of Ascending Aorta (c) Marfan's Syndrome PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from August 2, 1961 to August 11, 1961 that (I) (we) last saw the deceased alive on August 11, 1961 and that death occurred at 2:05 PM from the causes and on the date stated above. 22a. SIGNATURE <i>Harry R. Keiser M.D.</i> 22b. DATE SIGNED 8-11-61 22c. PHYSICIAN'S NAME (Type) Harry R. Keiser M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP R.R. 23b. DATE THEREOF 8-12-61 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) SCRANTON PA		24. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co Inc</i> 24b. ADDRESS <i>1400 Chapin St NW Wash D.C.</i> 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Keiser</i> 25c. DATE AUG 16 61	

MEDICAL CERTIFICATION

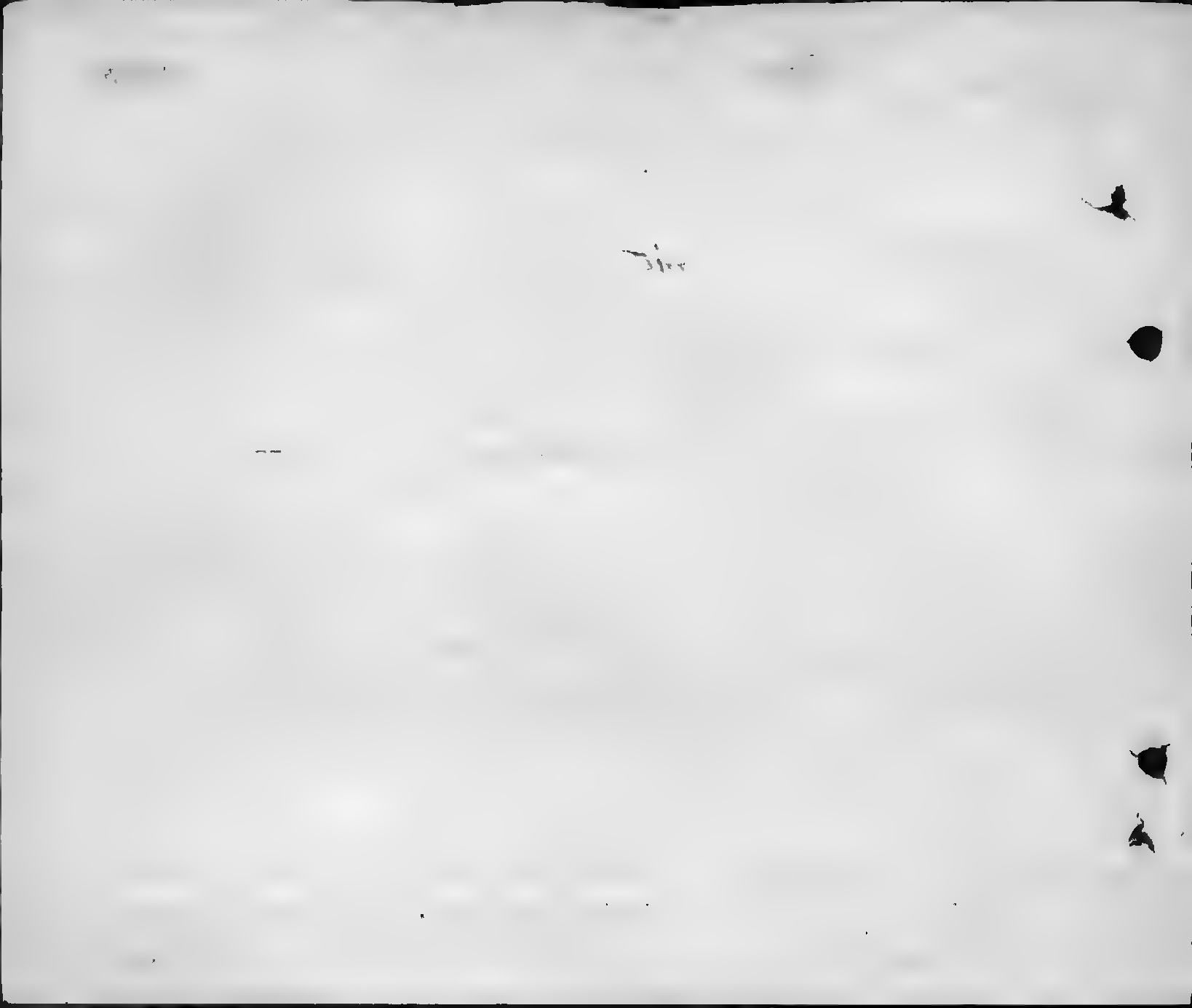
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR A **BINDING PHYSICIAN:** The law requires that the death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9240											
09230											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10420 Eastwood Ave.</u>							
3. NAME OF DECEASED (Type or print) <u>Nathaniel Merritt Batchelor</u>				4. DATE OF DEATH <u>Aug 21 1961</u>				b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4, 1907</u>		9. AGE (In years last birthday) <u>54</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Batchelor</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lancaster</u>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>unobtainable</u>				17. INFORMANT <u>Decedent</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperkalemia</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Renal Failure</u> DUE TO (c) <u>Aortic aneurysm, dissecting, ruptured - post-op.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).											
INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>34 hrs</u> <u>4 days</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August 16, 1961</u> , to <u>August 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 21, 1961</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Raymond J. Bradshaw, M.D.</u>											
22b. DATE SIGNED <u>Aug 21, 1961</u>											
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>											
22d. ADDRESS <u>345 Univ Blvd, N Silver Spring, Md.</u>											
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/23/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>			
23d. LOCATION (City, town or county) <u>Arlington, Virginia</u>				23e. (State) <u>Virginia</u>				23f. (Country)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The J.L. Hines Co.</u>											
ADDRESS <u>Washington DC.</u>											
25a. REC'D BY REGISTRAR <u>AUG 22 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>											



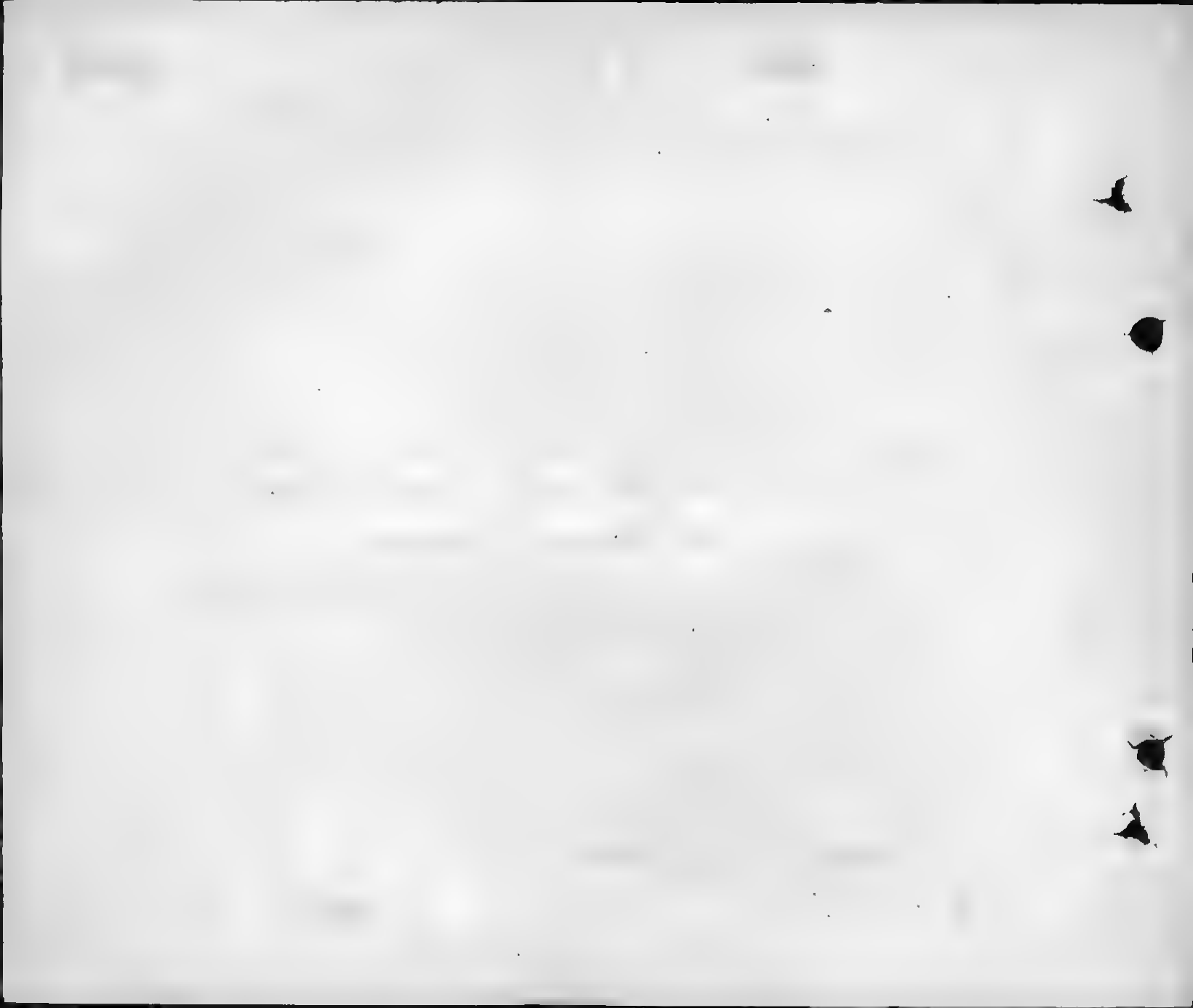
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9241

09231

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1801 Douglas Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Linwood</u> Middle <u>A.</u> Last <u>Bell</u>		4. DATE OF DEATH		Month <u>Aug</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/25/09</u>	9. AGE (In years lost birthday) <u>52</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>individual</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Bell</u>				14. MOTHER'S MAIDEN NAME <u>Clifford Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-10-056</u>		17. INFORMANT <u>Sadie Bell</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>						<u>1 d</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerosis</u>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1957</u> to <u>8/2/1961</u> , that (I) (we) last saw the deceased alive on <u>8/2/1961</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Stephen N. Jones</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>8/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		23b. DATE THEREOF <u>8/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Snowdon</u>				25a. REC'D BY REGISTRAR <u>DATE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hester</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9242											
09232											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 3 hrs.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington Sanitarium + Hospital				d. STREET ADDRESS 12117 Otis Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Samuel Charles Berk				4. DATE OF DEATH Month 8 - Day 17 Year 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-4-08		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 8 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Insurance				11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Berk				14. MOTHER'S MAIDEN NAME Lena Brown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 577-03 0124				17. INFORMANT Mrs Esther Berk Address 12117 Otis Dr Rockville			
18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Myocardial infarction DUE TO (c) Myocardial infarction				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 12 1/2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/17/61 to 8/17/61 , that (I) (we) last saw the deceased alive on 8/17/61 and that death occurred at 12 1/2 AM , from the causes and on the date stated above.											
22a. SIGNATURE CHARLES M. WEBER, MD				22b. DATE SIGNED 8/17/61							
22c. PHYSICIAN'S NAME (Type) CHARLES M. WEBER, MD				22d. ADDRESS 12600 PARKLAND DR. ROCKVILLE MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF AUG. 18, 1961				23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN			
23d. LOCATION (City, town or county) FALLS CHURCH VA.				23e. REC'D BY REGISTRAR Arthur L. Hines				23f. REGISTRAR'S SIGNATURE Arthur L. Hines			
24. FUNERAL DIRECTOR'S SIGNATURE B. Dampsky + Sons				24a. ADDRESS 3501-14 St. N.W.				24b. DATE AUG 24 '61			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9243

CERTIFICATE OF DEATH

09233

1. PLACE OF DEATH a. COUNTY Montgomery County,		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore h. STREET ADDRESS 812 Dunbarton Avenue			
3. NAME OF DECEASED (Type or print) Mary Bernadette BERRY		4. DATE OF DEATH August 20 1961		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland		9. AGE (In years last birthday) 40 yrs.	
11. BIRTHPLACE (Country & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Joseph Mellett	
14. MOTHER'S MAIDEN NAME Mary Flynn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Husband) Frank Hauthe Berry		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Rheumatic Heart Disease, mitral and aortic valve involvement</i> DUE TO causing the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Myocardial infarction</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER!)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	
20g. (County) Maryland		20h. (State) Maryland		21. I certify that (I) (this hospital) attended the deceased from August 17, 1961, to August 20, 1961, that (I) (we) last saw the deceased alive on August 20, 1961, and that death occurred at 1:00 AM on the causes and on the date stated above	
22a. SIGNATURE L. N. CAHILL, LCDR MC USN		22b. DATE SIGNED August 20, 1961		22c. PHYSICIAN'S NAME (Type) U.S. Naval Hospital, NNMC, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (and) Burial		23b. DATE THEREOF 8-24-61		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
23d. LOCATION (City, town or county) Baltimore		23e. (State) Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave.	
25a. REC'D BY REGISTRAR AUG 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume		25c. DATE AUG 23 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
9233 9244
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09234

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>		c. LENGTH OF STAY IN 1b <u>23 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15015 Rosecroft Road.</u>		d. STREET ADDRESS <u>15015 Rosecroft Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Stewart</u> Last <u>Black</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7, 1903</u>
9 AGE (In years last birthday) <u>58 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>/</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE THOMAS STEWART</u>		14. MOTHER'S MAIDEN NAME <u>HALLORAN, AGNES</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>578-32-2316</u>	
17 INFORMANT <u>AGNES H. STEWART</u>		Address <u>15015 Rosecroft Rd, Norbeck</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus.</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>/</u> DUE TO (c) <u>/</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>/</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Dec - 1959</u> to <u>Aug. 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 12 1961</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
22a SIGNATURE <u>William K. Ziegler</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) <u>William K. Ziegler</u>		22b DATE SIGNED <u>Aug 12, 1961</u>	
22d ADDRESS <u>202 Princess Anne Drive, Olney, Md.</u>			
23a BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>8/16/61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u>		ADDRESS <u>Silver Spring, Maryland</u>	
25a REC'D BY REGISTRAR <u>Walter E. Pumphrey, Inc.</u>		25b REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
DATE <u>AUG 17 '61</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

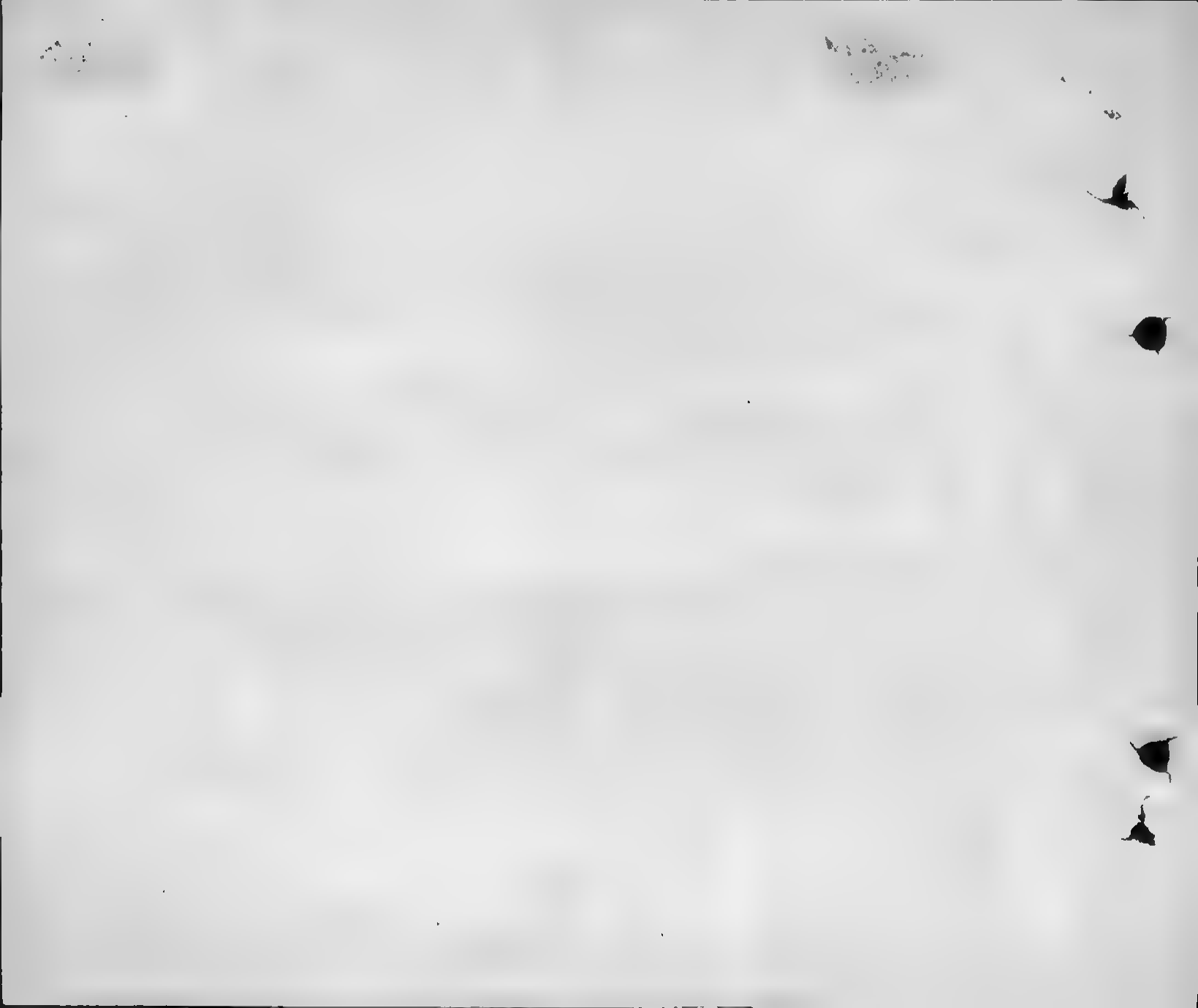
09235

1.2
FOR STATE
HEALTH DEPT.

9248

1. PLACE OF DEATH a. COUNTY: <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>15 Rockville</u>			
c. LENGTH OF STAY in 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>1119 S. Washington St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emily Yellott Blandford</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>housewife</u>				11. BIRTHPLACE (State or foreign country) <u>md</u>			
13. FATHER'S NAME <u>Deary W. Yellott</u>				14. MOTHER'S MAIDEN NAME <u>Nannie Gittings</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>Unknown</u>			
17. INFORMANT <u>John Elgin (Son-in-law)</u>				Address <u>P.O. Box 483 Rockville, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastrointestinal Hemorrhage</u> 570 } DUE TO (b) <u>Eroded Gastric Artery (Arteriosclerotic)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (c) <u>Acute Gastric Ulcer</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u> Interval between onset and death <u>Sudden</u> <u>Recent</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8-7-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/9/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Church Cem.</u>				22d. LOCATION (City, town, or country) (State) <u>Towson Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>			
24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>				DATE <u>AUG 10 61</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09236**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>4 1/2 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Silver Spring</u> d. STREET ADDRESS <u>18812 Second Ave</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nannie Josephine Boland</u> First Middle Last				4. DATE OF DEATH <u>Aug 4 1961</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-1879</u> 9. AGE (In years last birthday) <u>82</u> yr.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dep. Store</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter J. Boland</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Jenkins</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>577-01-5444</u>		17. INFORMANT <u>Nursing Home Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>153.3</u> IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>mon. Flu</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-4-61</u>				DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXXXXX</u>		22b. DATE THEREOF <u>8-7-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>WABNER E. PUMPHREY, INC.</u> ADDRESS <u>8434 Georgia Ave., Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 9 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, & 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the registrar for burial, cremation, or removal.

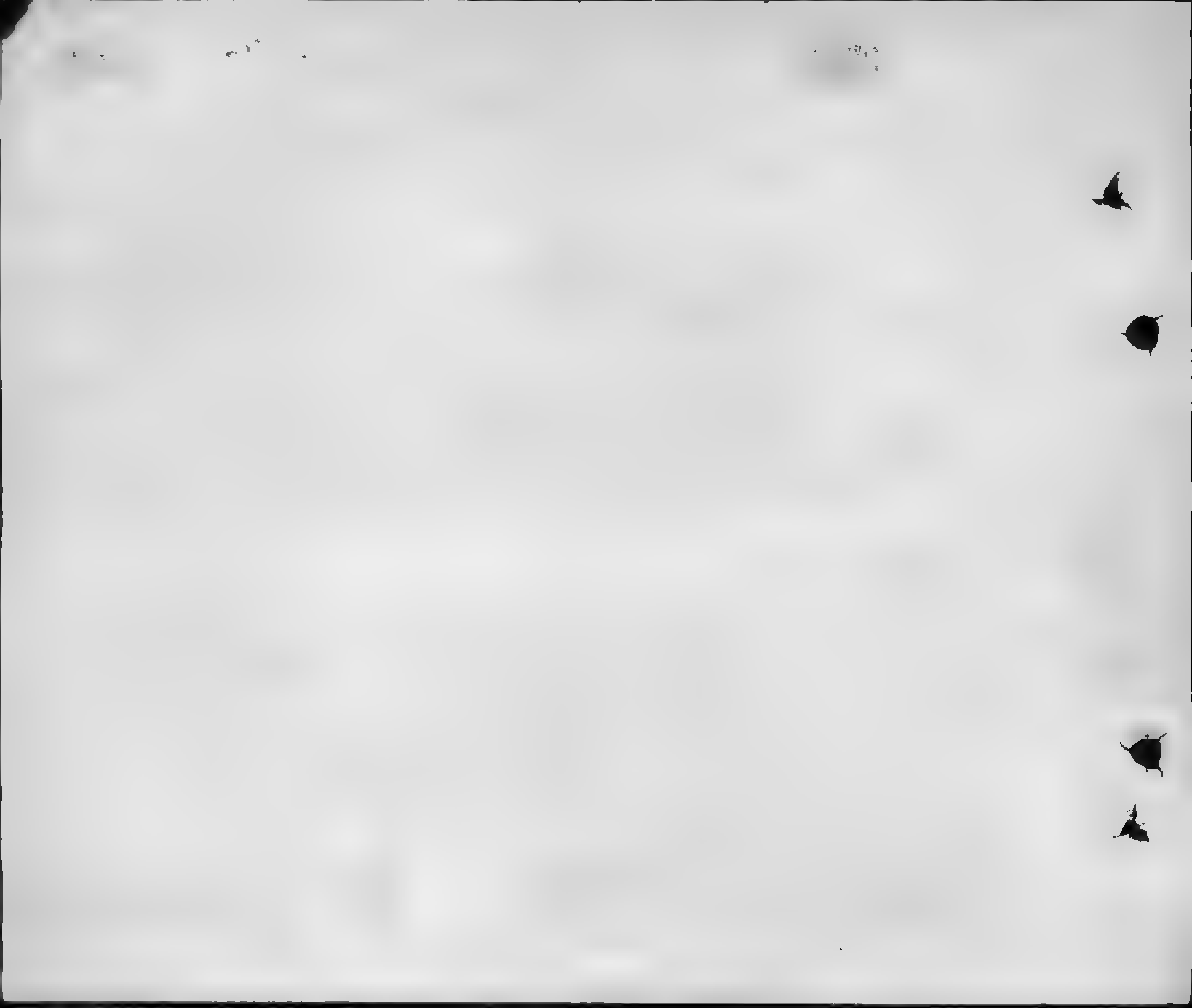


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5M 9 60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>708 Phila. Ave. Ewelen Nursing Home</u>		d. STREET ADDRESS <u>7216 Spruce Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Caroline Cooper Bowen</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. UNDER 1 YEAR: Months <u>8</u> Days <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. R. MacFarlane</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Cooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nursing Home Records</u>		18. ADDRESS <u>Nursing Home Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
(b) <u>Arterio Sclerosis heart disease</u>			
(c) <u>None</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> m. <u>00</u> p.m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u>8-2-61</u>			
22a. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>			
22b. LOCATION City, town, or county (State) <u>St. Louis, Mo.</u>			
23. FUNERAL DIRECTOR <u>J. Arthur Katter</u> 254 Carroll St. N. W.			
24a. REC'D BY REGISTRAR <u>Aug 3 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



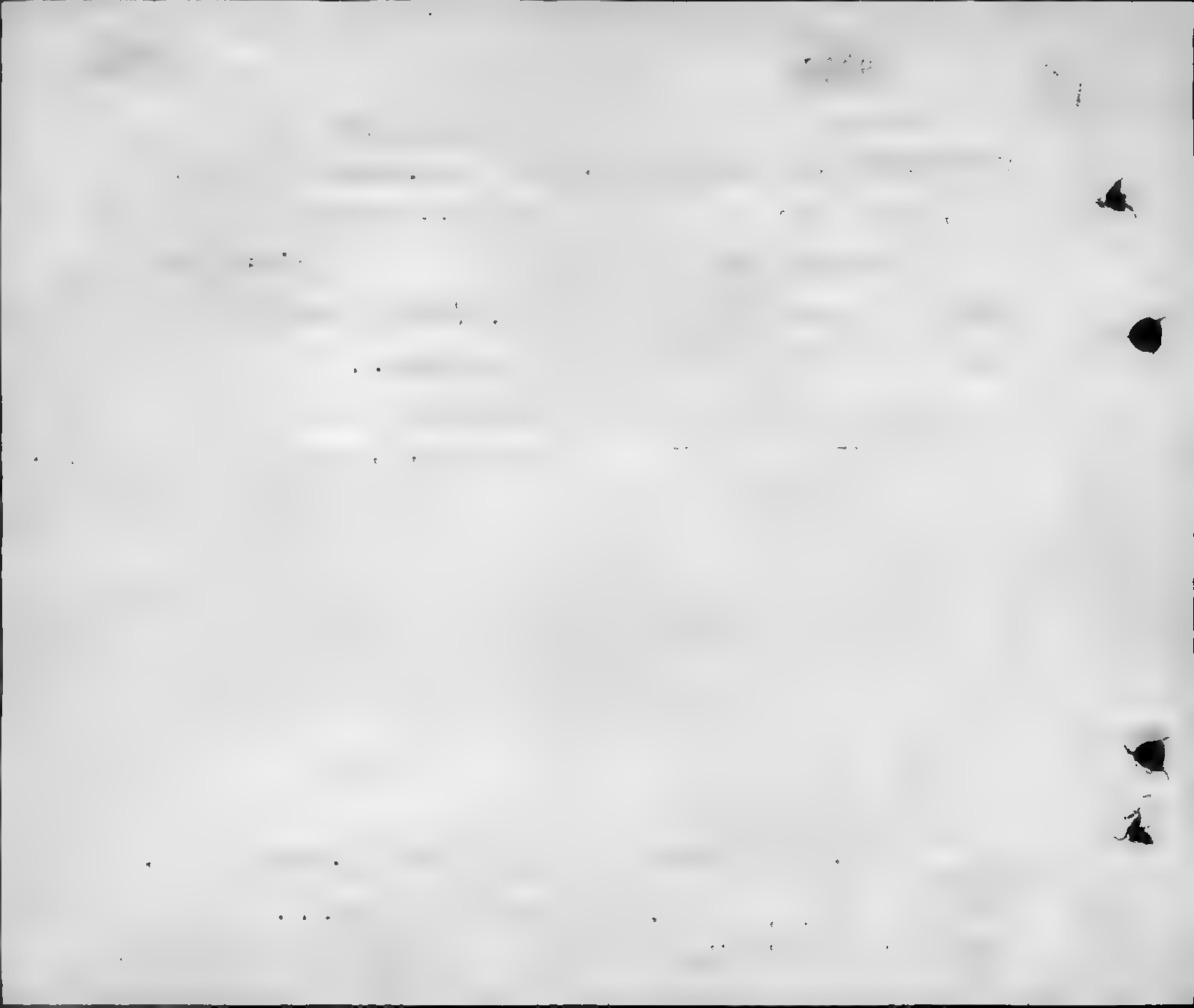
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9248

09238

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b June-Aug. 1961 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11,111 Lund Place		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY NEW YORK CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 200 W. 58th Street d. STREET ADDRESS 200 W. 58th Street	
3. NAME OF DECEASED (Type or print) Annie Marie Bowman 5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 12, 1880 9. AGE (In years, last birthday) 80 yrs. 10. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife retired 11. KIND OF BUSINESS OR INDUSTRY Own Home 12. CITIZEN OF WHAT COUNTRY? US		4. DATE OF DEATH Aug 17, 1961 9. AGE (In years, last birthday) 80 yrs. 10. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife retired 11. KIND OF BUSINESS OR INDUSTRY Own Home 12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Bifield 14. MOTHER'S MAIDEN NAME Annie Doyle Bifield		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO --- 17. INFORMATION J. Lee Sugrue, 11,111 Lund Place, Kensington, Md.	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) pneumonia DUE TO cerebral thrombosis (b) arteriosclerosis DUE TO congestive heart failure (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --- 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year June 19, 1961 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20d. (City or town) June 19, 1961 20e. (County) Montgomery 20f. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from June 19, 1961 to Aug 17, 1961 , that (I) (we) last saw the deceased alive on Aug 16, 1961 , and that death occurred at 1300 AM from the causes and on the date stated above.			
22a. SIGNATURE Sanford J. Randall 22b. PHYSICIAN'S NAME (Type) Dr. Sanford Randall		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 8329 Grubb Rd. Silver Spring Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL 23b. DATE THEREOF AUG. 19, 1961 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 23d. LOCATION (City, town or county) Wash. D.C.		25a. REC'D BY REGISTRAR AUG 21 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	
24. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond A. Ziska			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9249

CERTIFICATE OF DEATH

09239

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY N to M days <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital, Bethesda</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>102 Dawson Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Boyd</u>		4. DATE OF DEATH Last <u>Boyd</u> Month <u>August</u> Day <u>23</u> Year <u>1961</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Last <u>Boyd</u> Month <u>August</u> Day <u>21</u> Year <u>1961</u>		9. AGE (In years last birthday) <u>3</u> 10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE County & State, or foreign country <u>Montgomery, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Earl Luther Boyd</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Marie Howard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Father (same as above)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYDROCEPHALUS & MENINGOMYELOCELE</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>7-22X</u> DUE TO (c) <u>7-22X</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>			
20f. (City or town) <u>None</u>		20g. (County) <u>None</u>		20h. (State) <u>None</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>8-21-1961</u> to <u>8-23-1961</u> that (I) (we) last saw the deceased alive on <u>8-22-1961</u> and that death occurred at <u>8-23-1961</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert D. Whithen</u>		22b. DATE SIGNED <u>8-23-1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Bethesda</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 26, 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>			
23d. LOCATION (City, town or county) <u>Laytonsville</u>		23e. (State) <u>md.</u>		24. FURNER DIRECTOR'S SIGNATURE <u>Francis W. Barber</u>			
25a. REC'D BY REGISTRAR <u>SEP 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Orin L. Hanks</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

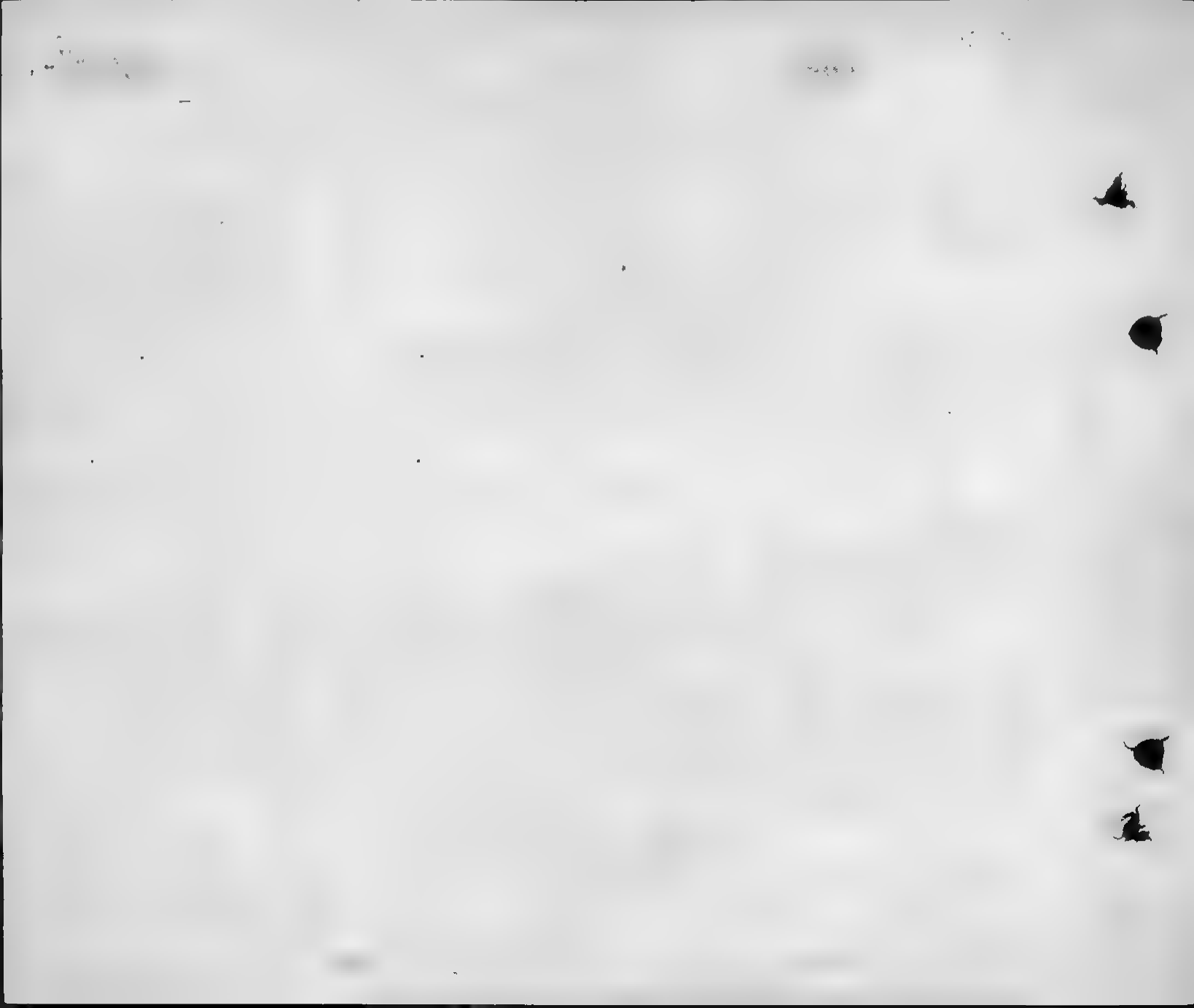
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9250											
09240											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 days				d. STREET ADDRESS 3545 Albemarle St., N. W.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Charles				F. DATE OF DEATH August 31				19 61			
5. SEX M				6. COLOR OR RACE W				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3/10/84				9. AGE (in years last birthday) 77 yrs.				10. IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Wash. D.C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Joseph Bradley				14. MOTHER'S MAIDEN NAME Mary Hooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes Army				16. SOCIAL SECURITY NO. Daughter Mrs. Lois Baker				17. INFORMANT Kensington, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, myelogenous, acute DUE TO Conditions, if any, which gave rise to immediate cause (b) Cause unknown (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Acute gastro-enteritis				19. INTERVAL BETWEEN ONSET AND DEATH 6 mos				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1958 to Aug. 31, 1961, that (I) saw the deceased alive on Aug 30, 1961, and that death occurred at 7 AM, from the causes and on the date stated above.											
22a. SIGNATURE Stewart Crapp				22b. DATE SIGNED 9.31.61				22c. PHYSICIAN'S NAME (Type) Stewart Crapp M.D.			
22d. ADDRESS 4740 Chevy Chase Dr.				22e. REC'D BY REGISTRAR Chevy Chase				22f. REGISTRAR'S SIGNATURE Arthur S. Knabe			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/5/61				23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.			
23d. LOCATION (City, town or county) Arlington				23e. DATE SEP 5 '61				23f. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home				24a. ADDRESS 503 3rd St. N.E. Wash. D.C.				24b. DATE SEP 5 '61			



9251

CERTIFICATE OF DEATH

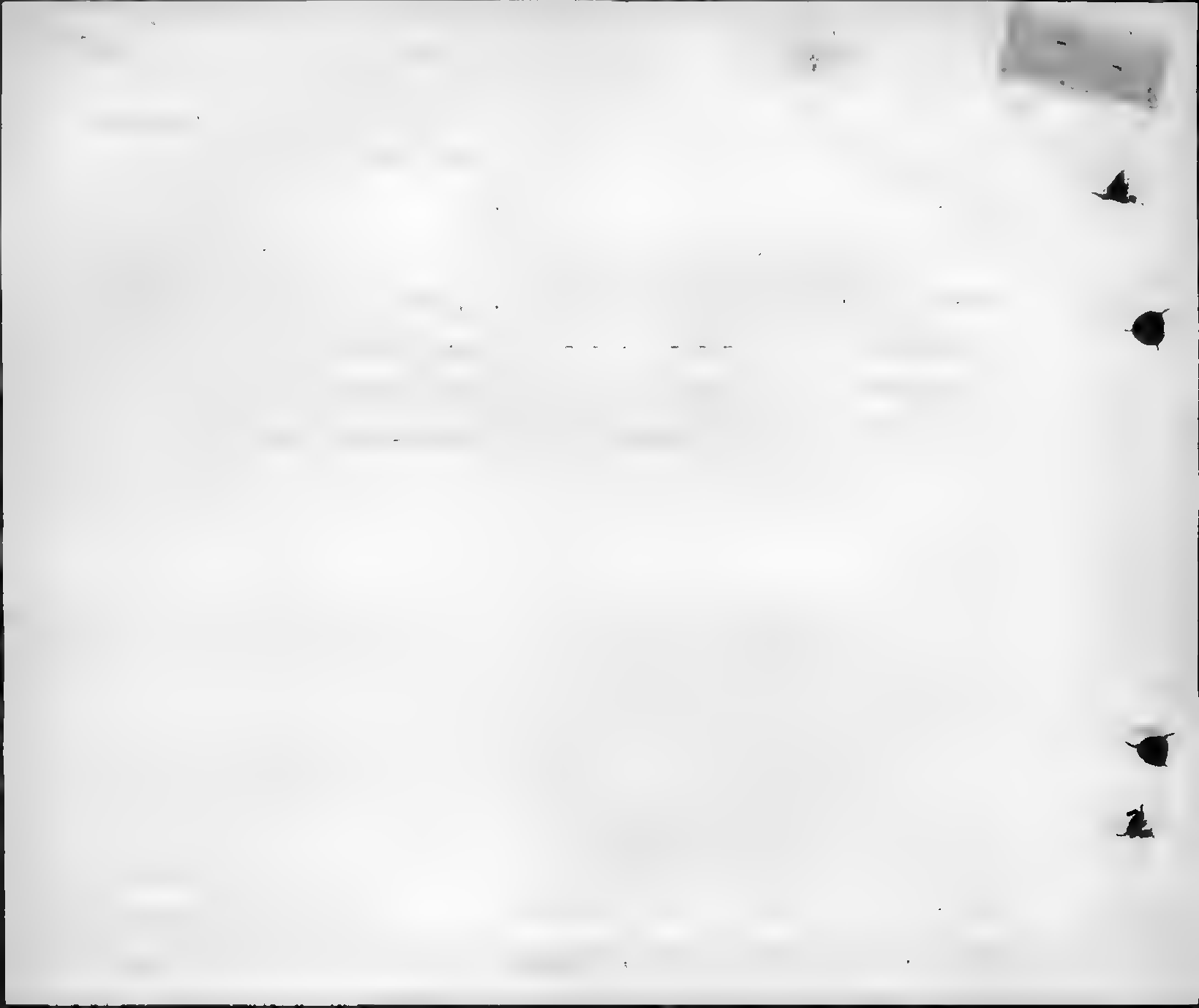
Reg. Dist. No.

09241

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a STATE Maryland b COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laytonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laytonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) Martha J. Bradshaw		4. DATE OF DEATH Month August Day 11 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1897
9. AGE (in years last birthday) 63		IF UNDER 1 YEAR Months 10 Days 3 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN Charles Samuel Tudor		14. MOTHER'S MAIDEN NAME Minnie Harriger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Samuel Tudor-Same Item #2 Son		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure			
DUE TO C-V-A.			
DUE TO Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-11-61 to 8-11-61 , that I last saw the deceased alive on 8-11-61 , 19 61 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lucinda I. Leal		ADDRESS (Street, city or town, state) Gaithersburg, Md.	
PHYSICIAN'S NAME (Type) Lucinda I. Leal		M.D. Gaithersburg, Md.	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial-trans	22b. DATE THEREOF 8/11/1961	22c. NAME OF CEMETERY OR CREMATORY Taylor Cemetery	22d. LOCATION (City, town, or county) (State) Falls Creek Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE AUG 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9252

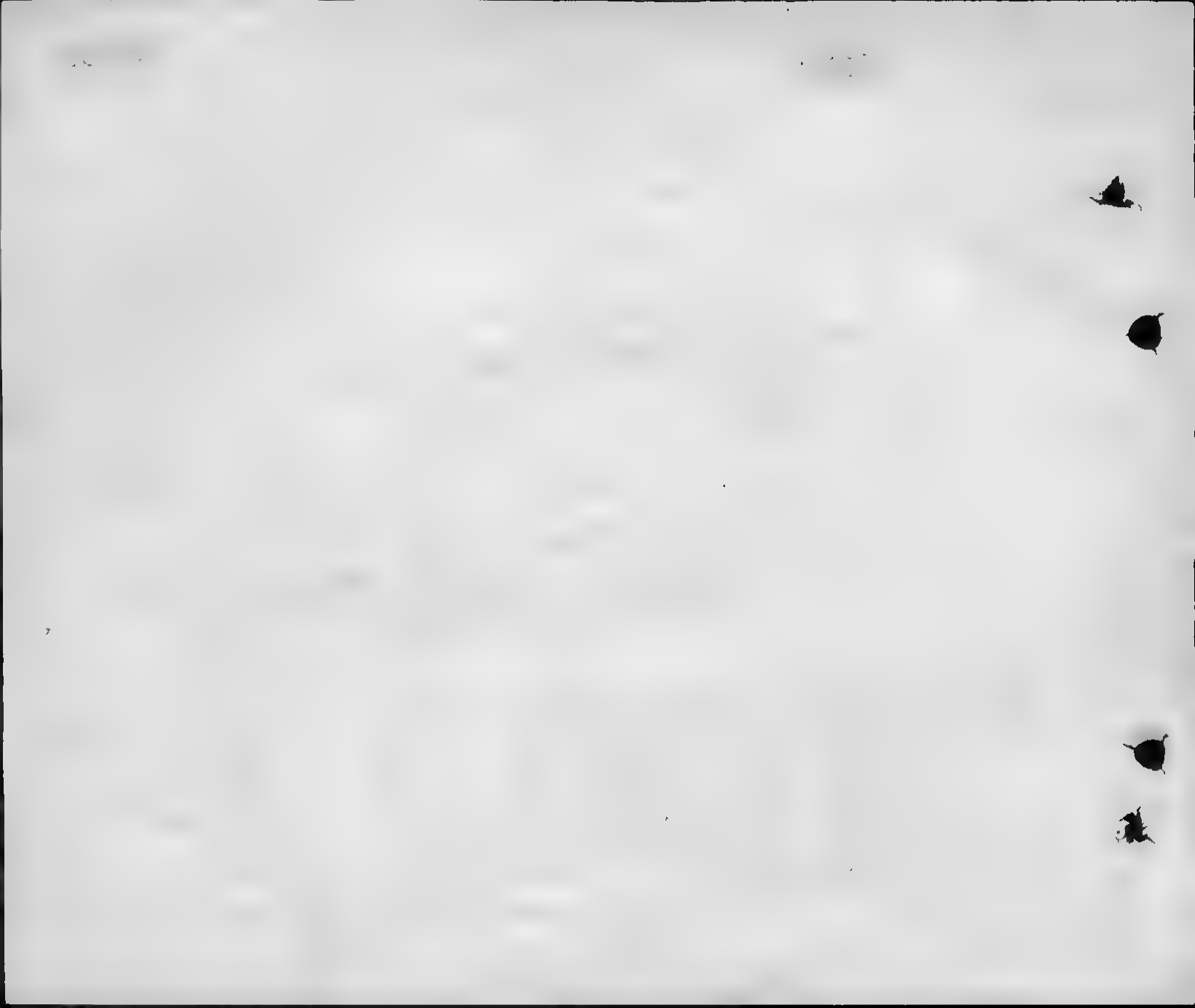
CERTIFICATE OF DEATH

09242

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 29 MIN. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution, has resided before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE d. STREET ADDRESS GAITHER ROAD a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY BOY "A" BROWN		4. DATE OF DEATH AUGUST 18 1961		5. SEX MALE			
6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 18, 1961			
9. AGE (In years, last birthday) 29		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY Co., MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME HERBERT EUGENE BROWN			
14. MOTHER'S MAIDEN NAME MILLIE MARIE HAMILTON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE			
17. INFORMANT FATHER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) Atellectasis (b) DUE TO Prematurity, one of the twins. (c) DUE TO Polyhydramnios of pregnancy. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 29 minutes.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 8-18-61 to 8-18-61, that (I) (we) last saw the deceased alive on 8-18-1961, and that death occurred at 9:15 AM, from the causes and on the date stated above.							
22a. SIGNATURE Sami Okutman		22b. DATE SIGNED 8-18-61		22c. PHYSICIAN'S NAME (Type) A. S. OKUTMAN, M. D.			
22d. ADDRESS SYKESVILLE, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 8-18-61		23c. NAME OF CEMETERY OR CREMATORY Rehman Memorial Park - Sykesville, Carroll Co. Md.		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight		25a. REC'D BY REGISTRAR AUG 29 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Haight			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

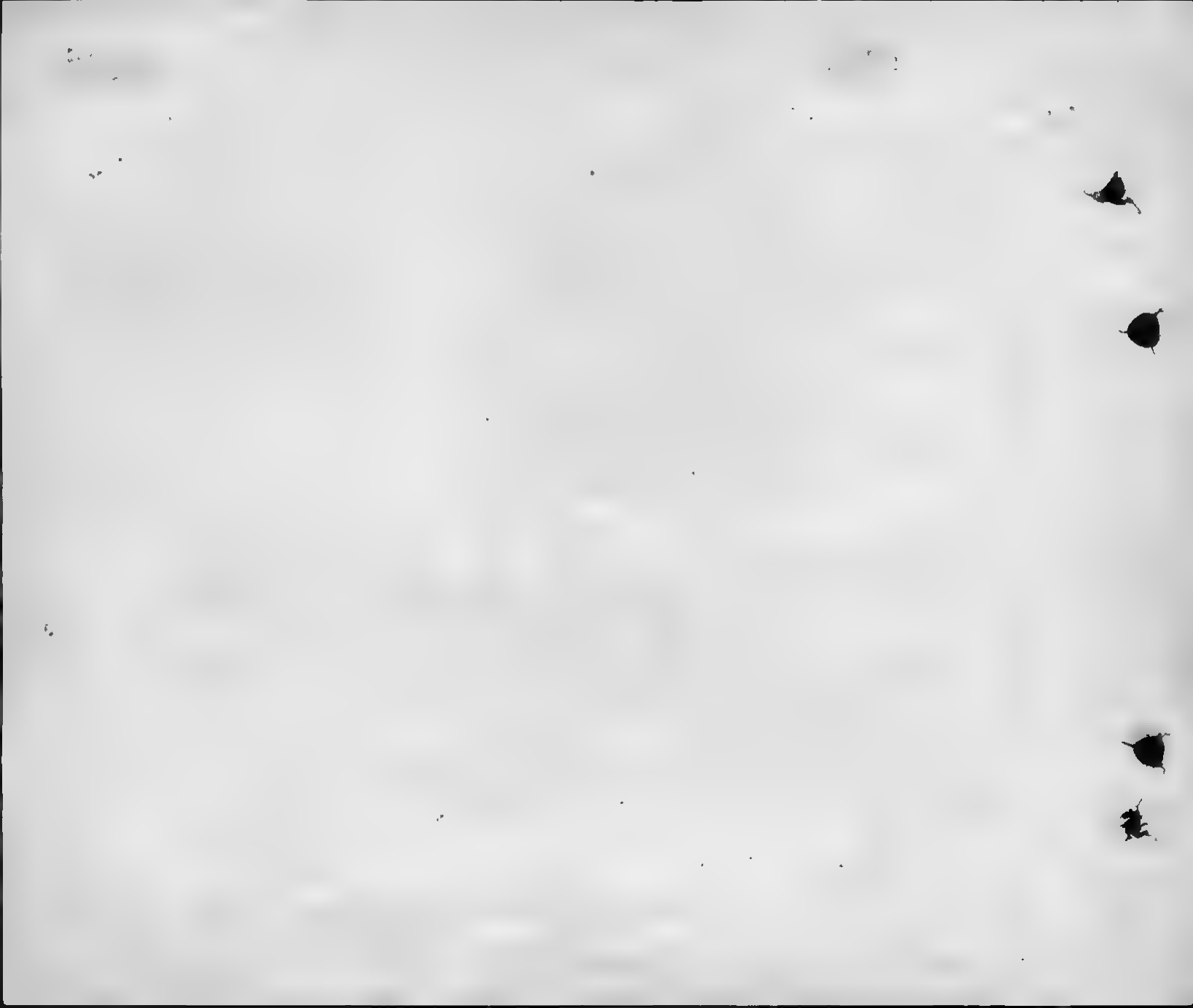
9253

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09243

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN TB 30 MIN. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE d. STREET ADDRESS GAITHER ROAD	
3. NAME OF DECEASED (Type or print) BABY BOY "B" BROWN		4. DATE OF DEATH Month AUGUST Day 18 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 18, 1961
9. AGE (In years last birthday) 0 yrs.		10. FUND 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY Co., MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME HERBERT EUGENE BROWN		14. MOTHER'S MAIDEN NAME MILLIE MARIE HAMILTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FATHER		Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Placental abruption DUE TO (b) Prematurity, one of the twins DUE TO (c) polyhydramnios of pregnancy. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH 3 E. minutes			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-18-61 to 8-18-61 , that (I) (we) last saw the deceased alive on 8-18-61 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Sam O. Okutman		22b. DATE SIGNED 8/18/61	
22c. PHYSICIAN'S NAME (Type) A. S. OKUTMAN, M. D.		22d. ADDRESS SYKESVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-18-61	
23c. NAME OF CEMETERY OR CREMATORY Robert W. Main Park		23d. LOCATION (City, town or county) (State) Sykesville, Carroll Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		25a. RECEIVED BY REGISTRAR 9/2/61	
25b. REGISTRAR'S SIGNATURE Arthur S. Haight		DATE	



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

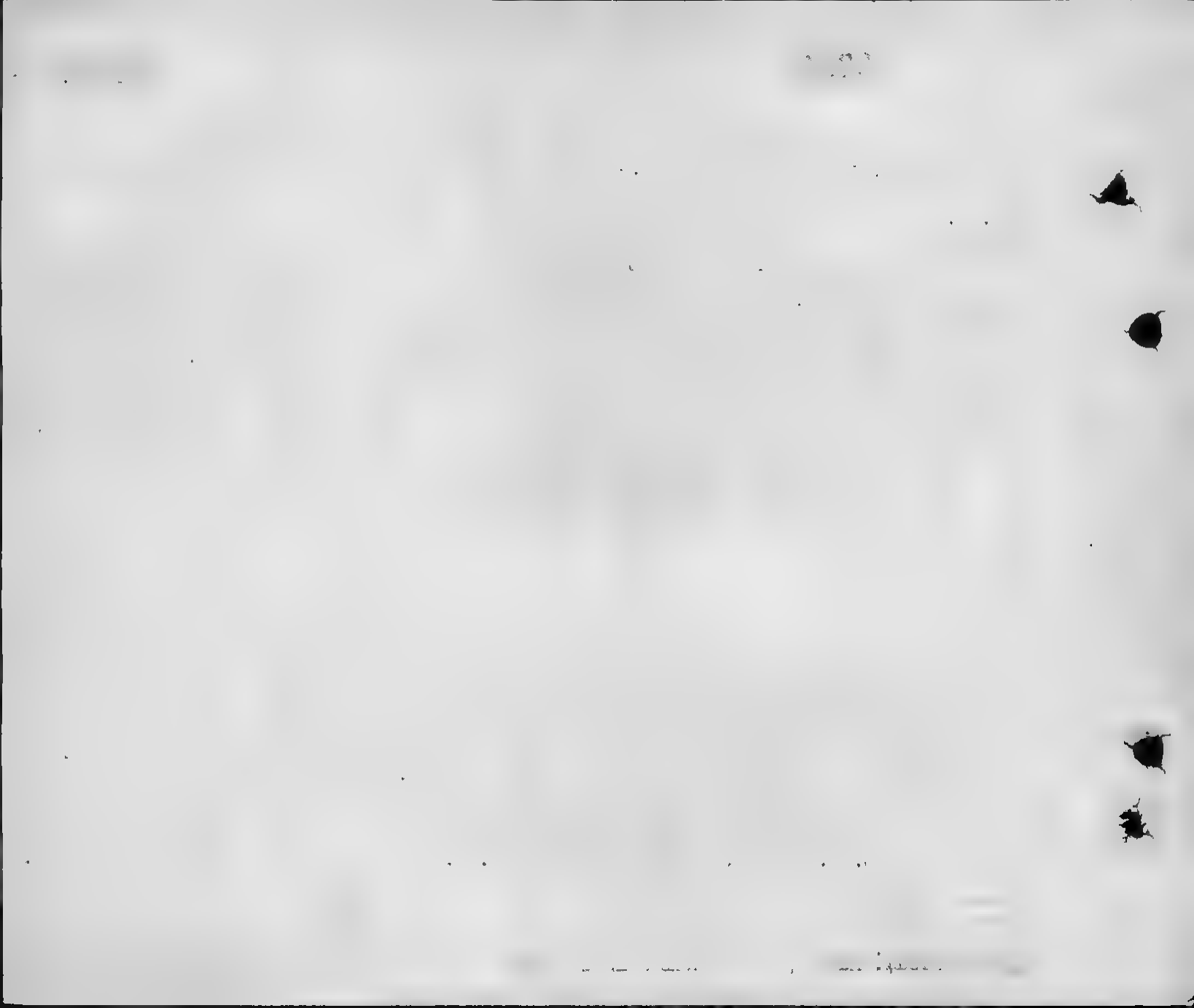
I

147

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9254
CERTIFICATE OF DEATH

09244

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN b. <u>1 Mo.-7 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> d. STREET ADDRESS <u>202 E. Tioga Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Pamela Lynn BUCK</u>		4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1961</u>					
9. AGE (In years last birthday) <u>4</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>4</u></td> <td>Days <u>1</u> Hours <u>1</u> M. n.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>4</u>	Days <u>1</u> Hours <u>1</u> M. n.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent Child</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months <u>4</u>	Days <u>1</u> Hours <u>1</u> M. n.						
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Frank Edward BUCK</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Jennie ARNOLD</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>(Father) Frank Edward BUCK</u>		Address <u>202 E. Tioga St., Philadelphia, Pa.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> <u>Congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12 July, 1961</u> to <u>19 August, 1961</u> , that (I) <u>did</u> last saw the deceased alive on <u>19 August, 1961</u> , and that death occurred at <u>7:55 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. N. CAHILL</u>		22b. DATE SIGNED <u>20 August 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>L. N. CAHILL, LCDR MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, NNMC, Bethesda, Md.</u>					
23a. BURIAL - CREMATION <u>Removal and</u>		23b. DATE THEREOF <u>21 Aug 1961</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Roslyn, Pennsylvania</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Humphrey</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 29 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinne</u>		25c. ADDRESS <u>Wilkey Funeral Home Philadelphia, Pa.</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

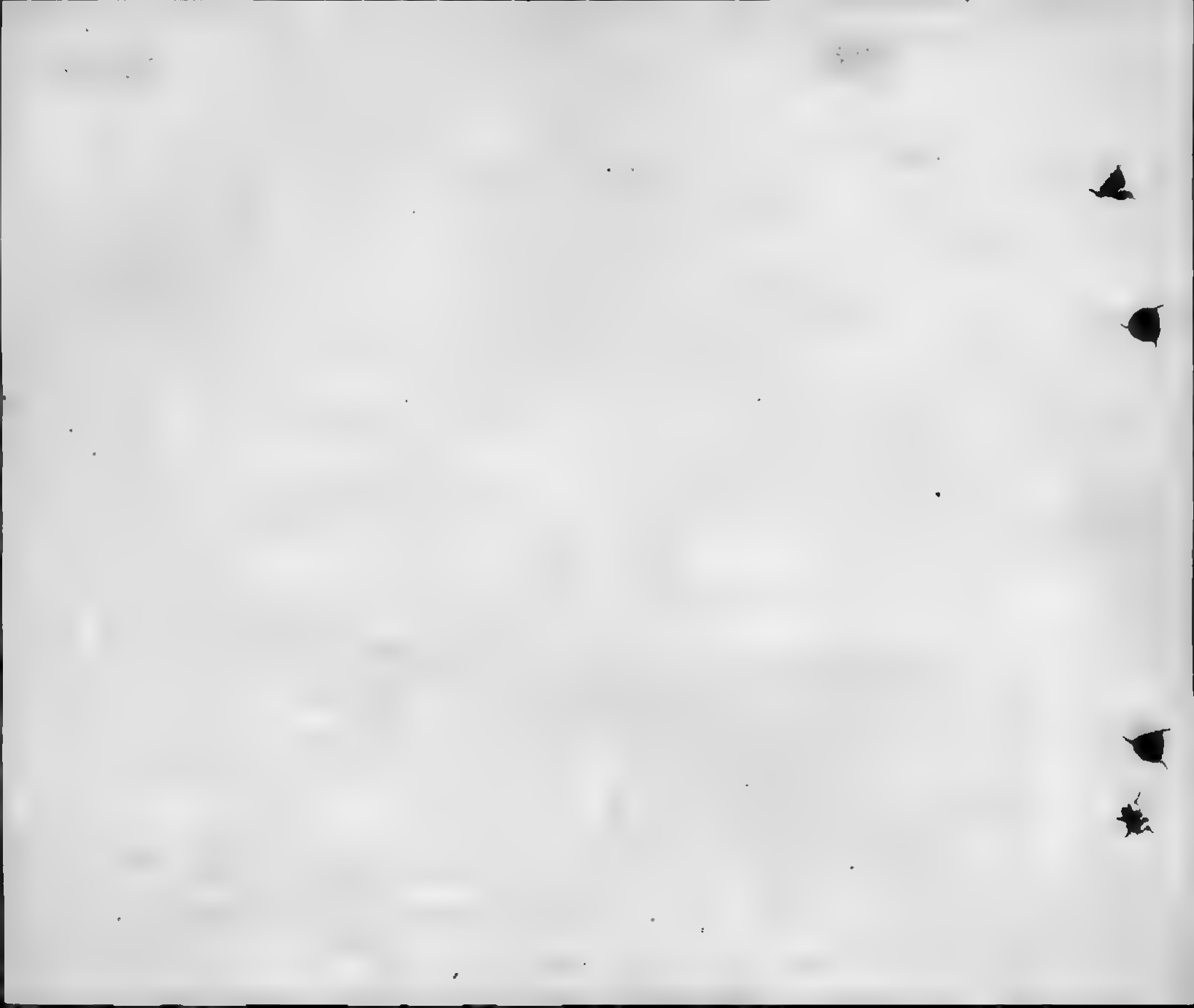
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9255

CERTIFICATE OF DEATH

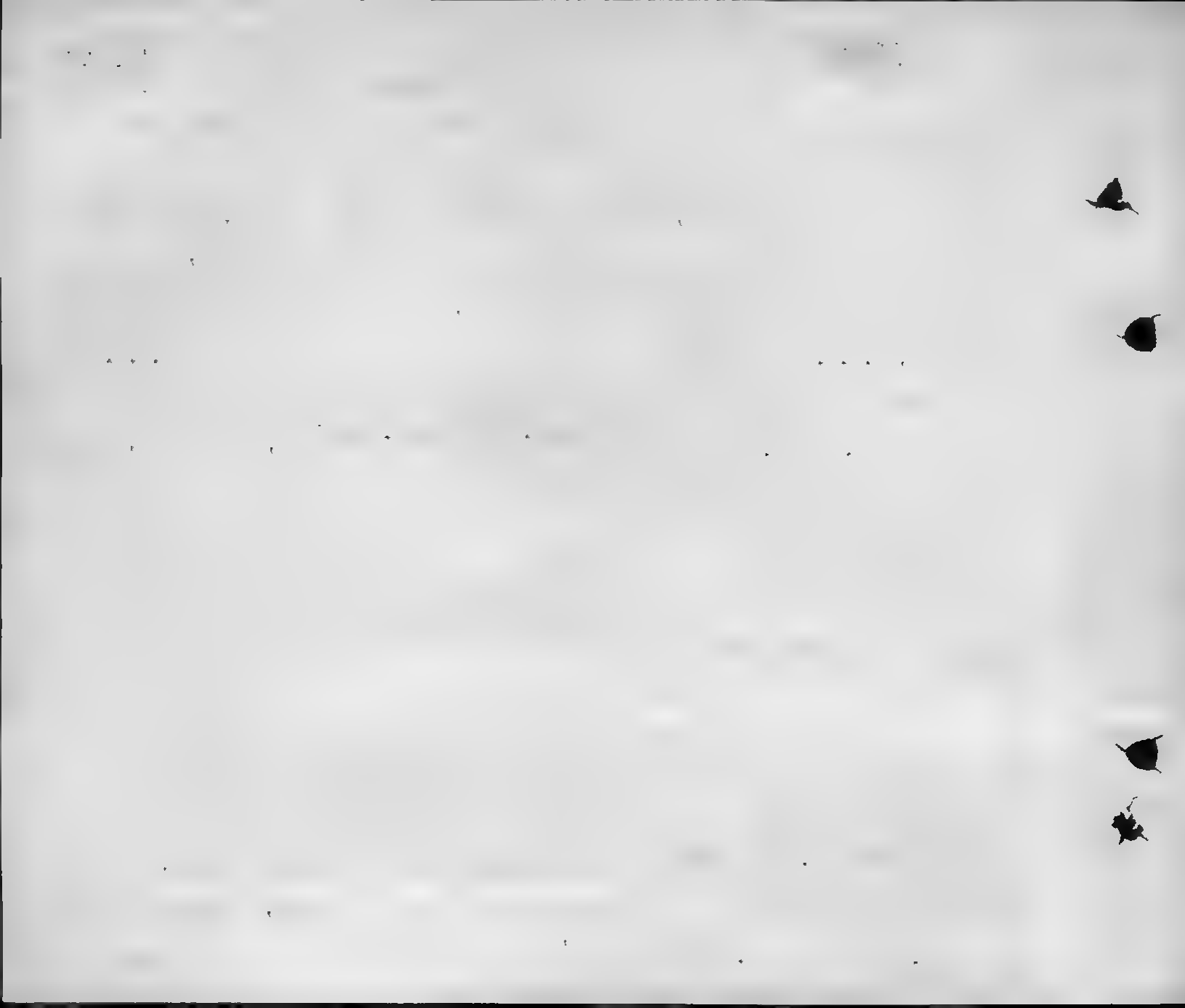
09245

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>46 Bethesda</u> d. STREET ADDRESS <u>8808 Lowell Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Jeffrey</u> Last <u>Buck</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1961</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>1</u> IF UNDER 24 HRS.: Hours <u>1</u> Min <u>0</u>
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Max Buck</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Valda Osburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Max Buck</u>		Address <u>8808 Lowell St. Bethesda, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.0</u> DUE TO <u>Conjunctive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Congenital heart disease (Tetralogy of Fallot)</u> (c) <u>3 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County, State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1961</u> to <u>Aug 23, 1961</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>Aug 1, 1961</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold M. Hobart</u>		22b. DATE SIGNED <u>8-23-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold M. Hobart</u>		22d. ADDRESS <u>5402 CONN. AVE. NW. Wash. 15 DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) <u>Prince Georges, Md.</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th St. NW</u> DATE <u>AUG 25 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finney</u>	



Robert L. Hunt

VS. A15ME
5M 7/59



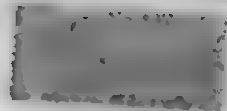
Item 20 Film 293 8-27 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09247

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>26 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery County Jail</u>		e. STREET ADDRESS <u>18 W. Montgomery Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Sherman Lee Burke</u>		4. DATE OF DEATH <u>Aug 17 1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1926</u>		
9. AGE (In years, if UNDER 1 YEAR, last b rth day) Months Days Hours M n. <u>34</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Andrew Jackson Burke</u>		14. MOTHER'S MARRIED NAME <u>Ida Light</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes, World War II</u>		16. SOCIAL SECURITY NO. <u>7-103-443-1</u>			
17. INFORMANT <u>Thorne W. Burk</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Edema</u> 14.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subdural Hematoma, left</u> (c) <u>Fractured Skull, left Parietal Bone (Compound)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <u>UNTERMINED fall</u>			
20c. TIME OF INJURY Month, Day, Year <u>1961</u> Hour <u>1:30</u> p.m. <u>Unknown</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>Unknown/Jail</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unknown/Jail</u>		20f. (City or town) (County) (State) <u>Unknown</u> <u>mont</u> <u>md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
SIGNATURE <u>Frank J. Broschant</u> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>8/19/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Sunset</u>		22d. LOCATION (City, town, or country) (State) <u>Christiansburg, Virginia</u>			
23. FUNERAL DIRECTOR <u>Lyon Wheeler</u>		24a. REC'D BY REGISTRAR <u>AUG 21 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		24c. ADDRESS (Street, city, town, or county) <u>8-18-61</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained or your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9258
CERTIFICATE OF DEATH

09248

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>21 days.</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		STREET ADDRESS <u>12802 Jennings Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>M.</u> Last <u>CARPENTER</u>		4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>February 26 1914</u>
9 AGE (In years last birthday) <u>47</u> yrs	IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>15</u> Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse M. Hawley</u>		14. MOTHER'S MAIDEN NAME <u>Eva Bulkey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>220-38-279</u>	
17 INFORMANT <u>John C. Carpenter</u> husband		Address <u>same as above</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infectious Glomerulo Nephritis</u> 26- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 YRS</u> <u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>August 7, 1961</u> to <u>August 7, 1961</u> , that (I) <u>lost</u> saw the deceased alive on <u>August 7, 1961</u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>DeWitt E. DeLawter</u>		22b. DATE SIGNED <u>8-8-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEWITT E. DeLAWTER, MD.</u>		22d. ADDRESS <u>8025 ABERDEEN Rd. Beth., Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>August 10 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hous</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9259

CERTIFICATE OF DEATH

09249

Item 1 Film G-294 9/2/61 iwk

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda LENGTH OF STAY IN 1b 6 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give name of address) Bethesda Suburban Hosp.
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Dist. of Columbia b. COUNTY Dist. of Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 4931-N. Capital. Apt 24
e. IS RESIDENCE ON A FARM? ☐ YES ☒ NO
3. NAME OF DECEASED (Type or print) Enrico Joseph Carpentieri
4. DATE OF DEATH Aug. 25 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/16/16 9. AGE (In years last birthday) 45 IF UNDER 1 YEAR: Months 11 Days 10 IF UNDER 24 HRS.: Hours 11 Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaner private 10b. KIND OF BUSINESS OR INDUSTRY Maryland, U.S.A. 11. BIRTHPLACE (County & State, or foreign country) Maryland, U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Vincent Carpentieri 14. MOTHER'S MAIDEN NAME Maria Riccone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 217-18-1874 17. INFORMANT same Address As Above.
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X DUE TO influenza bronchopneumonia
Conditions, if any, which gave rise to immediate cause (b) Conid
(a), stating the underlying cause last. (c) Cerebral Hemorrhage
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 4 days
INTERVAL BETWEEN ONSET AND DEATH 6 days
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 Aug 20, 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4pm 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 20, 1961 to Aug 25, 1961, that (I) (we) last saw the deceased alive on Aug 20, 1961, and that death occurred at 4pm from the causes and on the date stated above.
22a. SIGNATURE J.P. Murphy, M.D. 22b. DATE SIGNED Aug 25, 1961
22c. PHYSICIAN'S NAME (Type) J.P. MURPHY, M.D. 22d. ADDRESS 1904 R G Hw WASH. 9 DC
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF Burial 8/28/61 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery 23d. LOCATION (City, town or county) (State) Silver Spring, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Arthur E. Hennes ADDRESS 525 Bladensburg Rd. N.E. D.C. 25a. REC'D BY REGISTRAR Aug 28 '61 25b. REGISTRAR'S SIGNATURE Arthur E. Hennes



9260

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

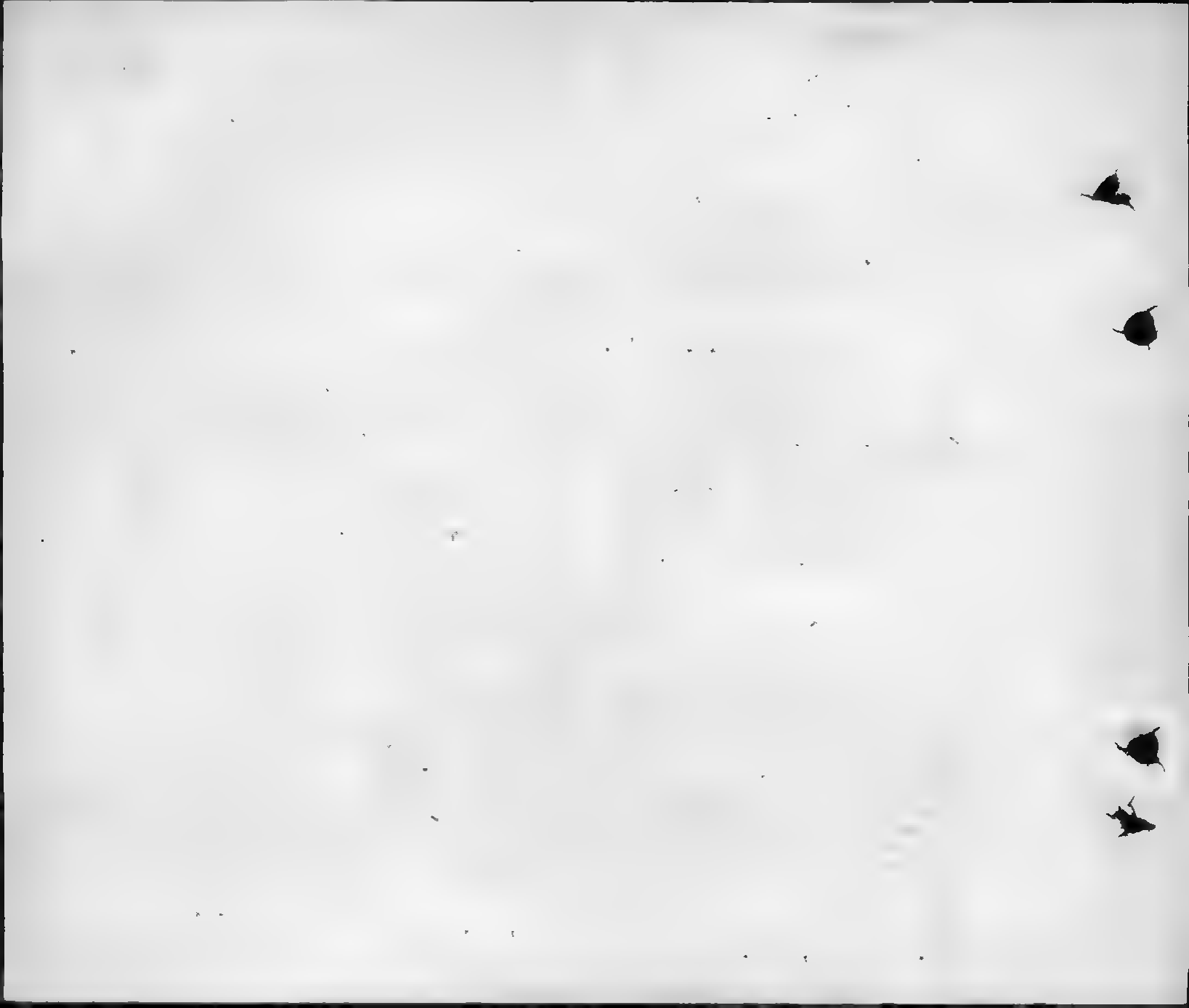
CERTIFICATE OF DEATH

09250

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mamie First ELIZABETH Middle CHEENEY Last		4. DATE OF DEATH Month AUG. Day 4 Year 1961	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JULY 28, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk (Ret)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	11. BIRTHPLACE (State or foreign country) Massachusetts
13. FATHER'S NAME WILLIS CHEENEY		14. MOTHER'S MAIDEN NAME LOUISE MORTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17 INFORMANT 2221 Address FOREST GLEN RD. M.R. W.M. CHEENEY SILVER SPRING, MD.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTIONS DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ATHEROSCLEROSIS (c) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 4-5 YRS. 5-7 YRS. -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CA COLON OPERATED 1955- NON CONTRIBUTORY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from FEB. 22, 1958 to AUG. 4, 1961 , that (I) (we) last saw the deceased alive on AUG. 4, 1961 , and that death occurred at 7:50 M. from the causes and on the date stated above			
22a. SIGNATURE James A. Roberts M.D.		22b. DATE SIGNED AUG. 4, 1961	
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		22d. ADDRESS 8907 GEC. AVE. SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/7/61	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City, town, or county) (State) Washington D.C.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska Warner E. Pumphrey, Inc. 8434 Georgia Avenue		25a. REC'D BY REGISTRAR DATE AUG 9 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hanna

I

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		August 4, 1961	Arlington National		Fort Myer Va.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
W. W. Chambers		5801 Cleveland Ave. Riverdale, Md.		DATE AUG 3 '61		Arthur S. Kraus

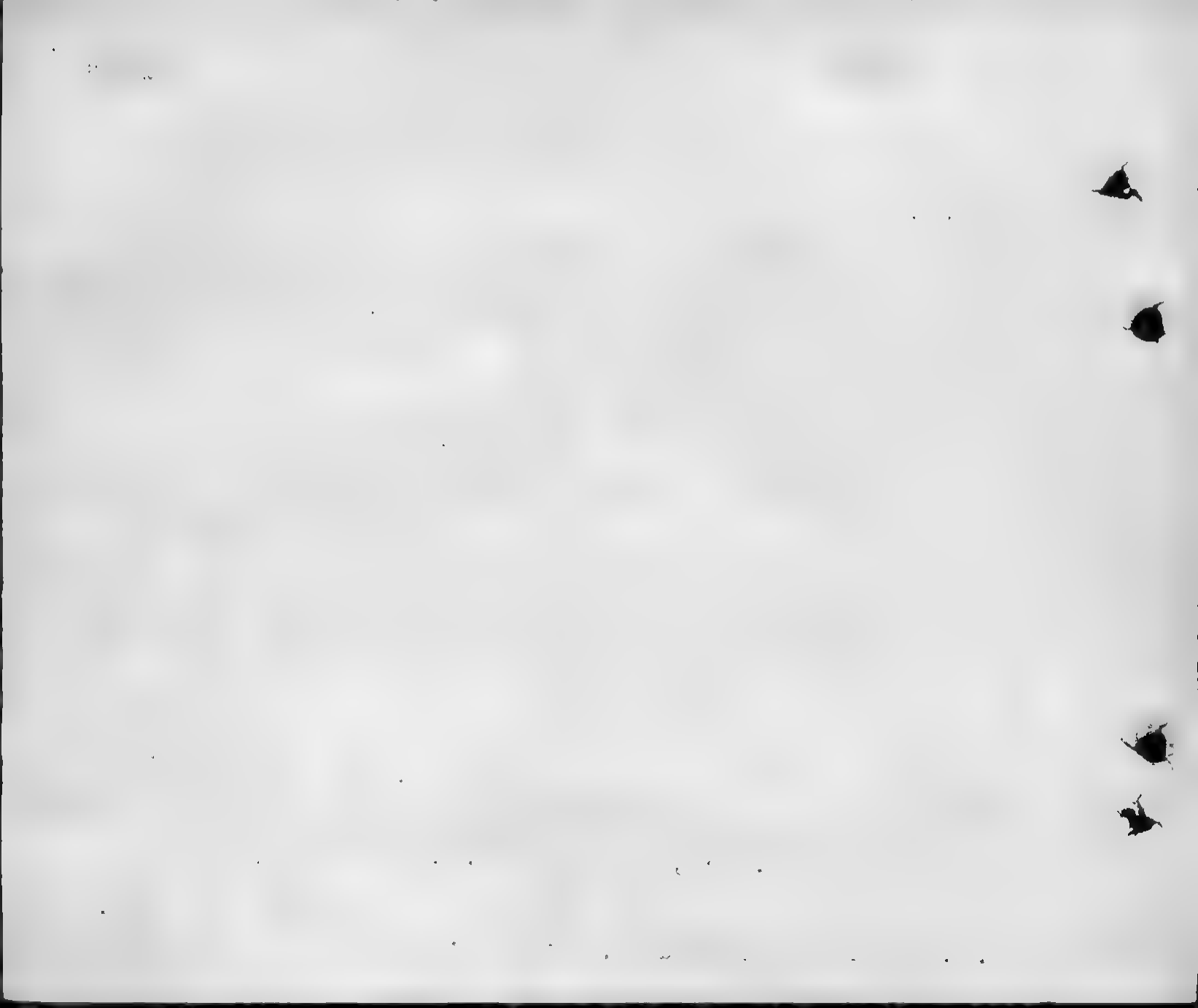
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN IL 4 Hrs & 13 Min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Hyattsville	
3. NAME OF DECEASED (Type or print) Timothy		4. DATE OF DEATH August 1 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 1, 1961		9. AGE (In years last birthday) yrs Months Days		IF UNDER 1 YEAR Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (County & State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Paul A. Chretien		14. MOTHER'S MAIDEN NAME Kathleen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Paul A. Chretien		17. INFORMANT Same as # 2 above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)		Erythroblastosis fetalis		congenital	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (this hospital) attended the deceased from August 1, 1961 to August 1, 1961 that (X) (we) last saw the deceased alive on August 1, 1961, and that death occurred at 7:40 AM from the causes and on the date stated above.					
22a. SIGNATURE Lawrence G. Thorne		22b. DATE August 1, 1961		22c. PHYSICIAN'S NAME (Type) Lawrence G. Thorne, LT MC USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. SIGNATURE	

23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		August 4, 1961	Arlington National		Fort Myer Va.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
W. W. Chambers		5801 Cleveland Ave. Riverdale, Md.		DATE AUG 3 '61		Arthur S. Kraus

05107781



9262

CERTIFICATE OF DEATH

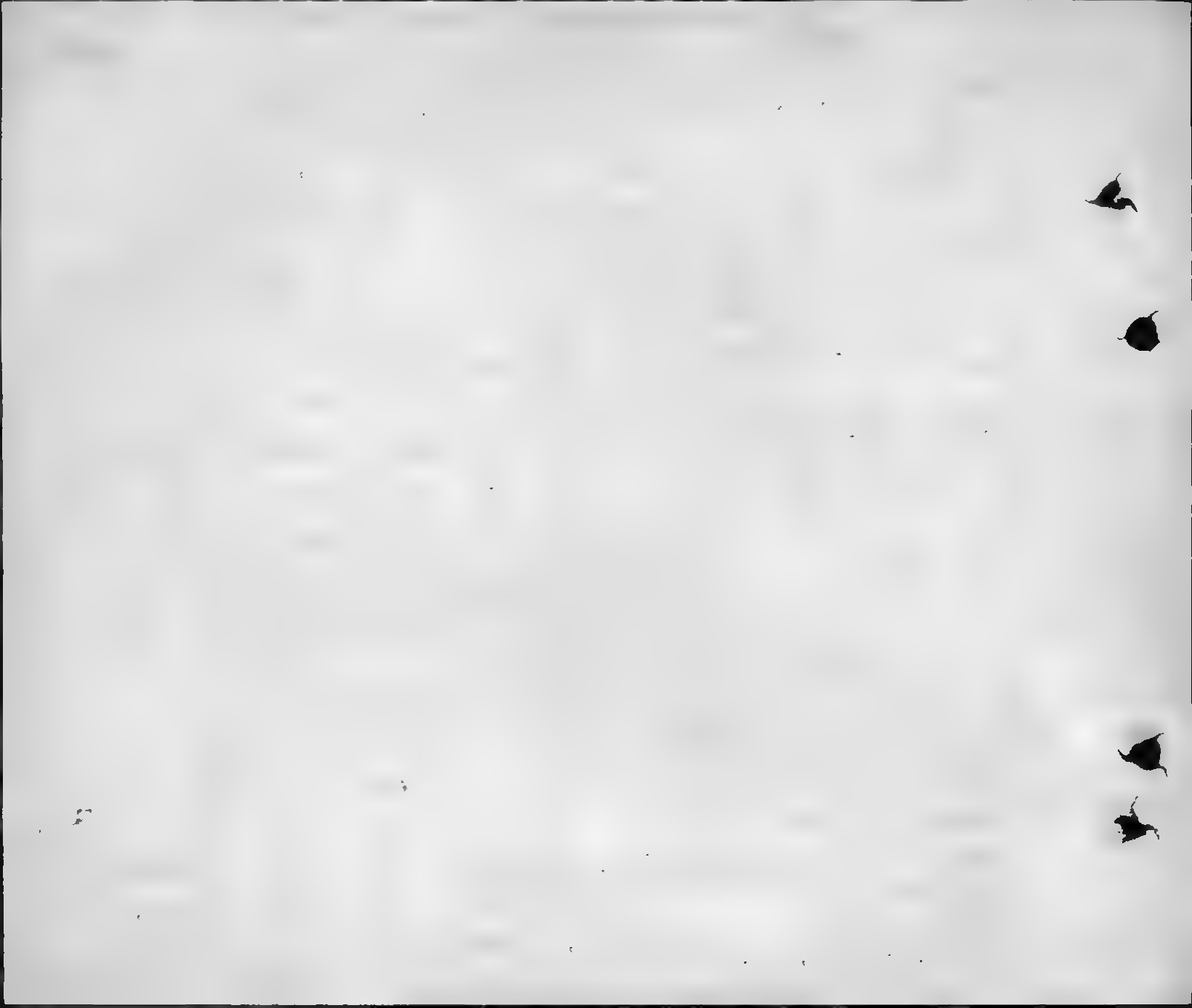
Reg. Dist. No.

11252

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ednor		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12318 Wheaton, Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) BELMONT NURSING HOME		d. STREET ADDRESS x Ednor, Md	
3. NAME OF DECEASED (Type or print) First ROBERT Middle CLARK Last CLARK		4. DATE OF DEATH Month 8 Day 2 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/1976
9. AGE (In years last birthday) yrs. 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTOGRAPHER	
10b. KIND OF BUSINESS OR INDUSTRY US GOVT.		11. BIRTHPLACE (State or foreign country) MICHIGAN	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT H. CLARK	
14. MOTHER'S MAIDEN NAME EVA JACKSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT NURSING + MEDICAL RECORD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) DUE TO (c) DUE TO PULMONARY EMBOLUS CONGESTIVE HEART FAILURE ARTERIOCLEROTIC CARDIOVASCULAR DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). RECENTLY POSTOPERATIVE (PROSTATECTOMY)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year blow on pt. 9/19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/9 , 19 61 , to 8/2 , 19 61 , that I last saw the deceased alive on 7/31 , 19 61 , and that death occurred at 11:25 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John P Martin MD, Sandy Spring, Md JOHN P MARTIN, MD SANDY SPRING, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/4/61	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince George's County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		24a. REC'D BY REGISTRAR DATE AUG 7 '61	
24b. REGISTRAR'S SIGNATURE Charles L. Fries			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL, OR AN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

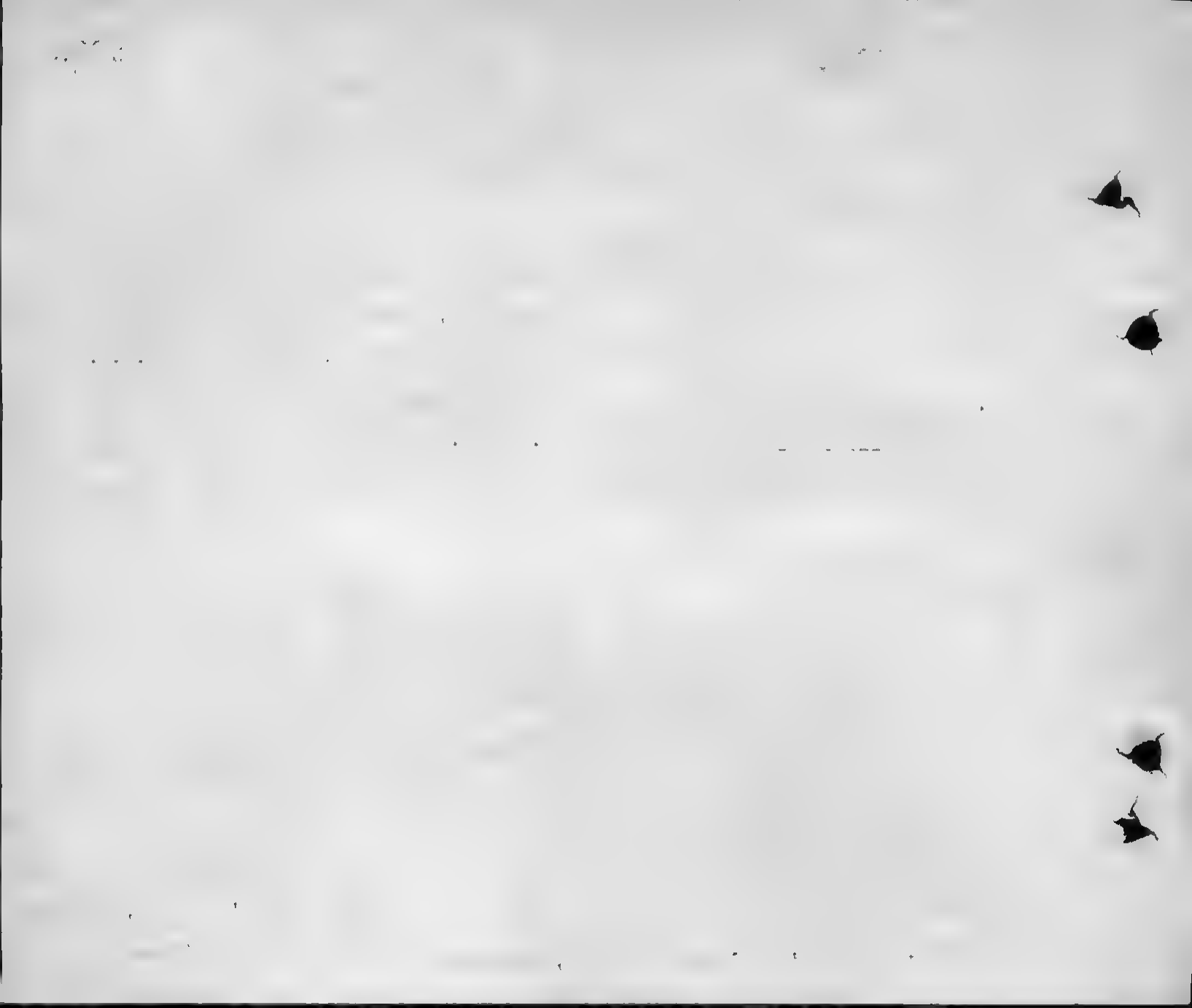
VR A15 (4)
15M 9/60

M

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Montgomery		Silver Spring		Maryland		Montgomery	
c. LENGTH OF STAY IN b		12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
717 Ritchie Ave.				717 Ritchie Ave.			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
Sarah Emma Clark				8-16-		1961	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years, if UNDER 1 YEAR, IF UNDER 24 HRS., list birth day Months Days Hours Min.)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
F	W		August 21, 1884	76 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Housewife				Own Home			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Mr. James Harvey				Georgianna Goddard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO			
No				NONE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				INTERVAL BETWEEN ONSET AND DEATH			
Malnutrition				2 months			
DUE TO				Many years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
Carcinomatosis							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town)	
Hour a.m. p.m.		While at work Not While at work				(County) (State)	
19		<input type="checkbox"/> <input type="checkbox"/>					
21. I certify that (I) (the hospital) attended the deceased from... August 14, 1961, to August 16, 1961, that (I) (the) last saw the deceased alive on August 14, 1961, and that death occurred at 9 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
Bennet A. Porter, Jr., M.D.				August 16, 1961		Bennet A. Porter, Jr., M.D.	
22d. ADDRESS				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
9301 Colesville Rd., Silver Spring, Md.				AUG 21 '61		Arthur S. Hanna	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)	
Burial		8/19/61		Fort Lincoln Cemetery		Prince George's County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Warner W. Humphrey, Inc.				AUG 21 '61			
8434 Georgia Avenue Silver Spring, Maryland				25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

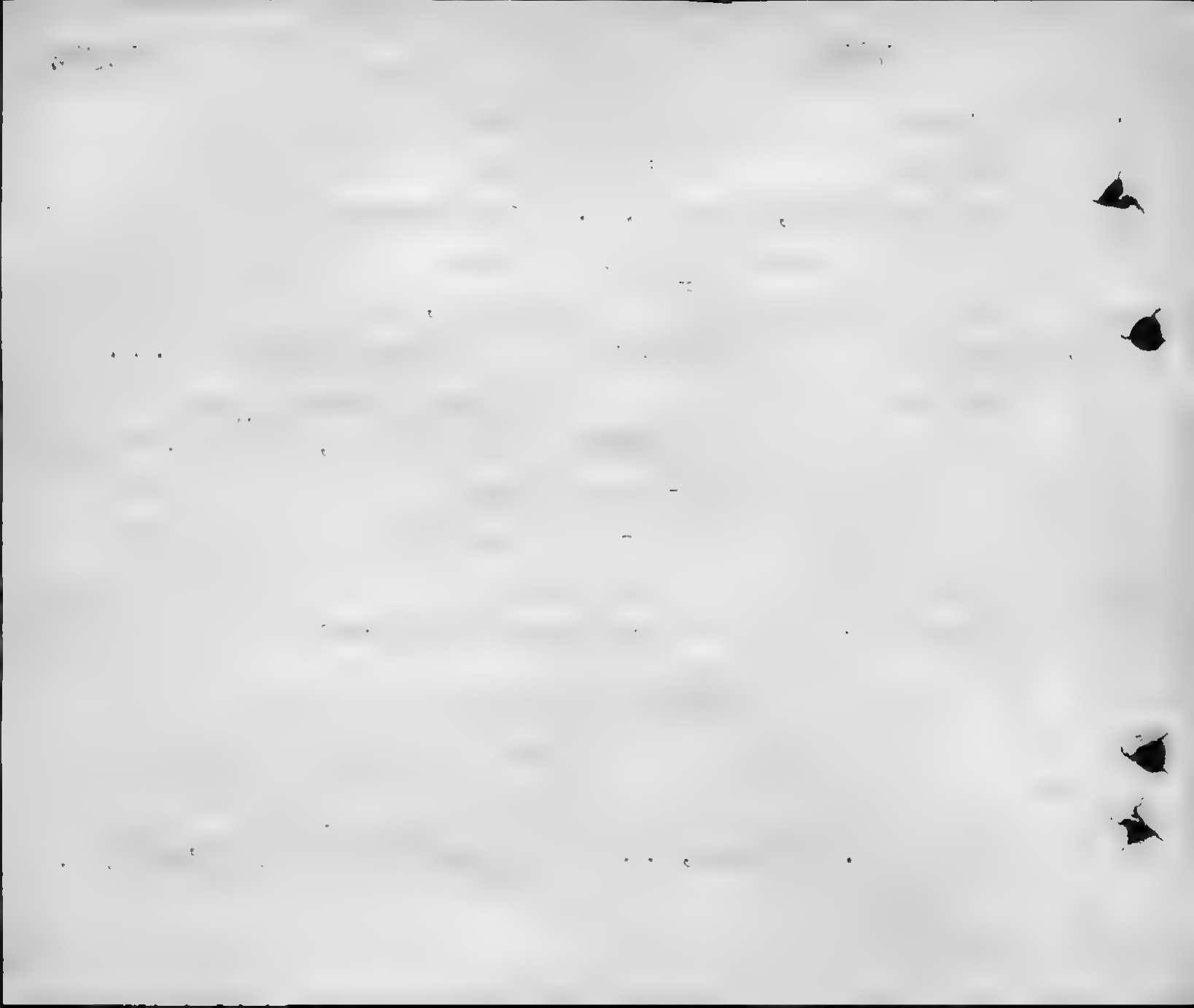
M

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
9264 CERTIFICATE OF DEATH 09254															
Items 2, 11, 14 & 16 Fill 0297 10/2/61 mh															
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 73 days				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Detroit d. STREET ADDRESS 760 8th Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				3. NAME OF DECEASED (Type or print) Solly (None) Cohen				4. DATE OF DEATH August 12 1961				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH January 15, 1915			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spotter				10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning				11. BIRTHPLACE (County & State, or foreign country) New York Toronto, Can.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Issac Cohen				14. MOTHER'S MAIDEN NAME Bessie Solly Schaaltes				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 562-12-9579			
17. INFORMANT The Medical Record				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory arrest DUE TO Widespread Epidermoid Carcinoma (Primary - left Alveolar ridge) Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 3 days post-operative Medullary Tractotomy for Intractable Pain				19. INTERVAL BETWEEN ONSET AND DEATH 12 hours 6 months				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18.) <input type="checkbox"/>				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>				20f. (City or town) <input type="checkbox"/>				20g. (County) <input type="checkbox"/>				20h. (State) <input type="checkbox"/>			
21. I certify that (a) (this hospital) attended the deceased from May 31 to August 12, 1961 , that (b) (we) last saw the deceased alive on August 12, 1961 , and that death occurred at 9:15 AM from the causes and on the date stated above.															
22a. SIGNATURE J. Kent Trinkle				22b. DATE SIGNED 8/12/61				22c. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				22d. PHYSICIAN'S NAME (Type) J. Kent Trinkle, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF AUG 15 1961				23c. NAME OF CEMETERY OR CREMATOR CHESED-SHEL EMMA'S				23d. LOCATION (City, town or county) (State) HILLSIDE Md			
24. FUNERAL DIRECTOR'S SIGNATURE Danzon & Sons				24a. ADDRESS 3501-14th St. NW.				25a. REC'D BY REGISTRAR AUG 24 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

VR A (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

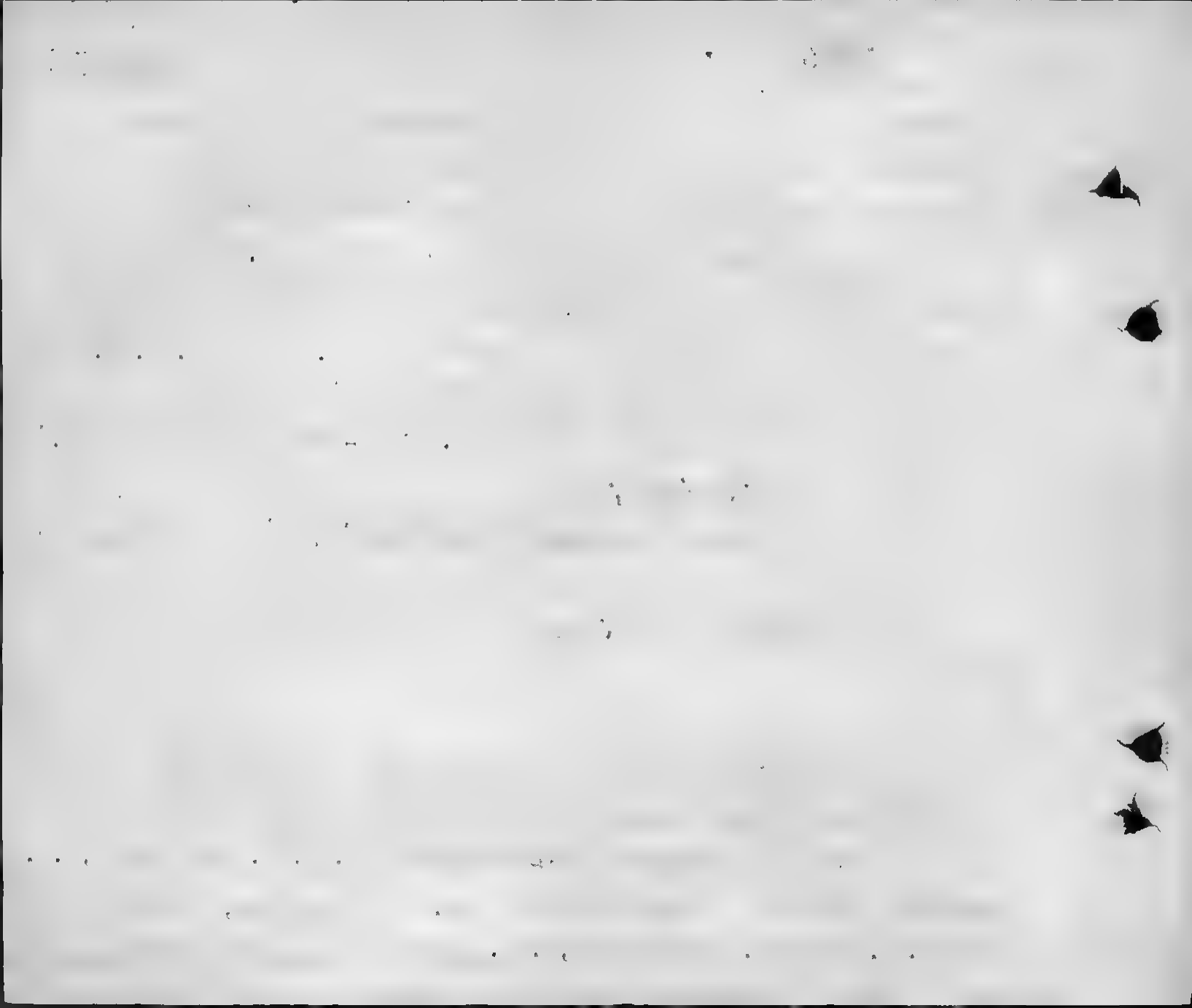
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9265

09255

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>6710 Hillandale Road</u>	
3. NAME OF DECEASED (Type or print) <u>Persis</u> First Middle Last <u>C. Coiner</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4/26/1905</u> 9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Fairfax Conrad</u>		14. MOTHER'S MAIDEN NAME <u>Martha Proudfit</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) <u>Peritonitis</u> DUE TO (b) <u>Perforated Appendicitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Ulcerative Colitis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 wks</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/22</u> <u>1961</u> , to <u>8/19/1961</u> , that (I) (we) last saw the deceased alive on <u>8/19/1961</u> , and that death occurred at <u>2:15</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Leon Gerber</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>LEON GERBER M.D.</u>		22d. ADDRESS <u>1800 Eye St. N. W. Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>8/19/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ware Episcopal Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Gloucester, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>AUG 21 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			



9266

CERTIFICATE OF DEATH

Reg. Dist. No. 09256

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
c. LENGTH OF STAY in 1b <u>84 yrs.</u>				d. STREET ADDRESS <u>417 E. Reservoir Rd NW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kesner Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Thomas Collins</u>				4. DATE OF DEATH <u>August 16 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1877</u>	
9. AGE (in years last birthday) <u>84 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banker</u>		11. BIRTHPLACE (State or foreign country) <u>Georgetown, Wash. D.C.</u>	
13. FATHER'S NAME <u>Andrew Collins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Ryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-12-1079</u>		17. INFORMANT <u>Mrs. Jennie H Collins</u> Address <u>417 E. Reservoir Rd NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>425</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>D. in car</u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/11/61</u> 19 <u>61</u> to <u>8/16/61</u> 19 <u>61</u> , that I last saw the deceased alive on <u>8/15/61</u> 19 <u>61</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>417 E. Reservoir Rd NW</u> DATE SIGNED <u>8/16/61</u>			
ACTUAL SIGNATURE <u>Charles J. Savarese</u> M.D.				PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat.</u>		22d. LOCATION (city, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Chase Funeral Home</u> ADDRESS <u>5103</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



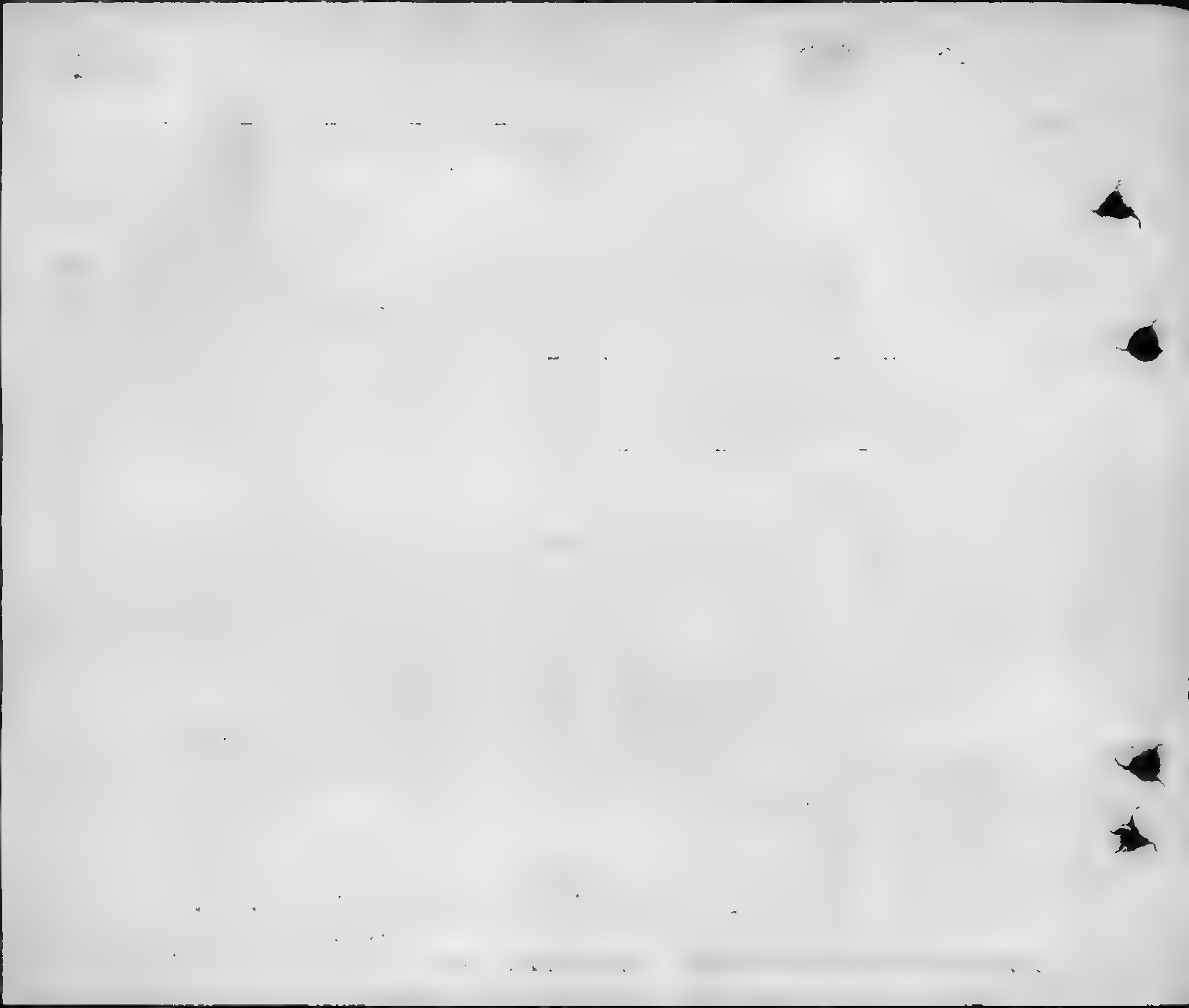
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

BP

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
09257											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D</u> b. COUNTY <u>47X</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>				d. STREET ADDRESS <u>1821 SUMMIT PL N.W.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KESHOR HOSPITAL + SAN.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARY HOWARD CORBETT</u>				4. DATE OF DEATH <u>AUGUST 27 1961</u>							
5. SEX <u>F</u>				6. COLOR OR RACE <u>W</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>AUG 26 1871</u>				9. AGE (In years last birthday) <u>90</u> yrs.				10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State or foreign country) <u>ARLINGTON, VA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>CHARLES CORBETT</u>				14. MOTHER'S MAIDEN NAME <u>MARY HOWARD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>PAUL WALTER</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Congestion</u> Conditions, if any, which gave rise to immediate cause (b) <u>UREMIA</u> (a), stating the underlying cause last. (c) <u>DIVERTICULITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 days</u> <u>8 days</u>				19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/23 1961</u> to <u>8/27 1961</u> , that (I) (we) last saw the deceased alive on <u>8/27 1961</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert G. Brewer</u>				22b. DATE SIGNED <u>8/27/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER</u>				22d. ADDRESS <u>8218 WISCONSIN AVE BETHesda, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>8-30-1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			
23d. LOCATION (City, town or county) <u>Suitland. Md.</u>				23e. (State) <u> </u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paul's Law</u>				24a. ADDRESS <u>Wash, D.C.</u>				25a. REGISTRY REGISTRAR <u>Aug 29 61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>				25c. DATE <u> </u>							

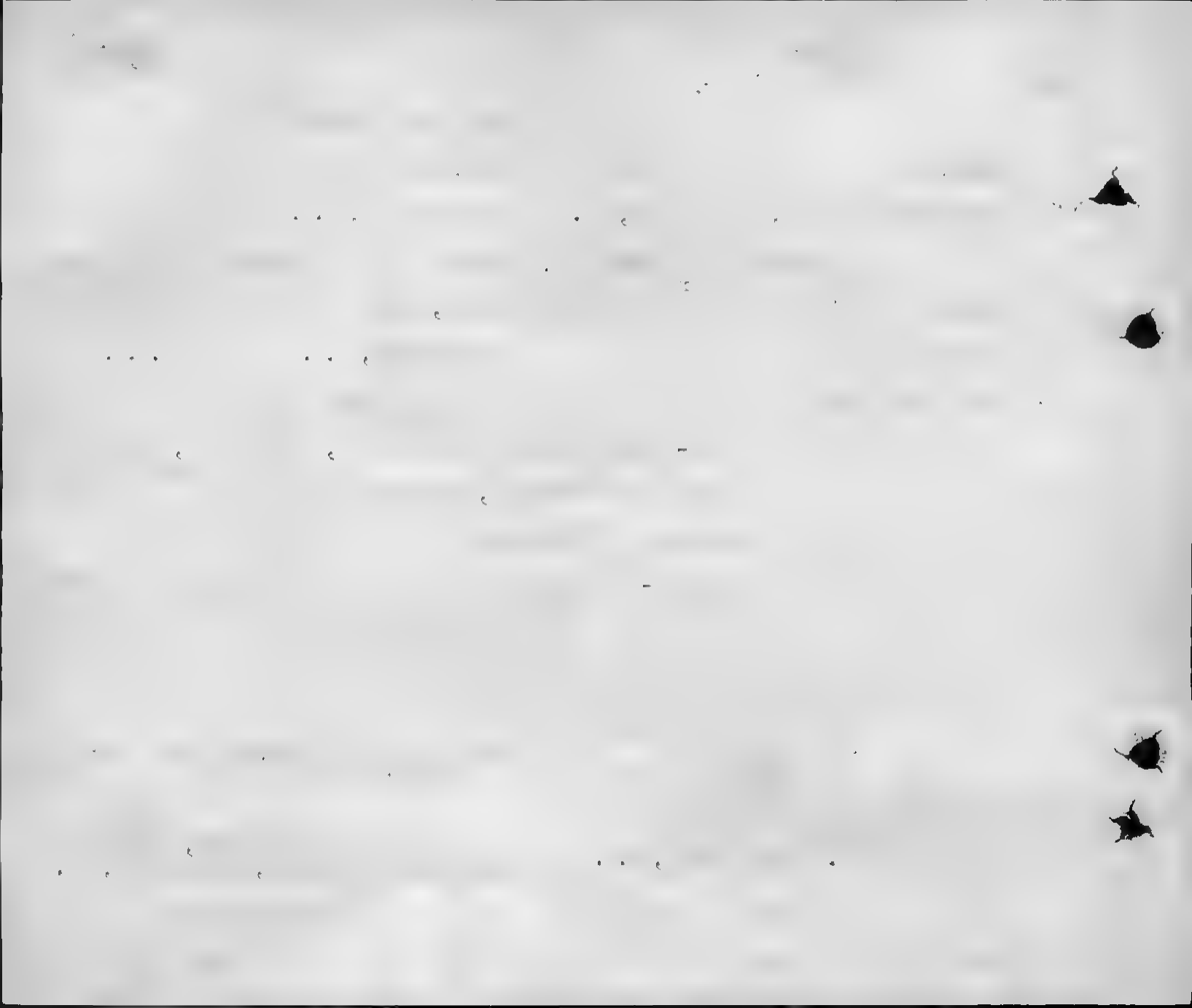


TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9268
CERTIFICATE OF DEATH
09258

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda c. LENGTH OF STAY (in days) 29 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 234 Eye Street, S.W.	
3. NAME OF DECEASED (Type or print) Mildred Eugene Costanzo		4. DATE OF DEATH Month August Day 1 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1927	
9. AGE (in years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 33 Days 7 Hours 12 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (Country & State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Kittredge		14. MOTHER'S MAIDEN NAME Mildred Mercer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-30-5105	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral atelectasis, Respiratory failure & right heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hypertension DUE TO (c) Myxoma - left atrium	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 hours 8 years 8 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 12:57 AM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Clinical Center, National Institutes of Health, Bethesda 14, Md.		20f. (City or town) WASHINGTON DC.	
20g. (County) District of Columbia		20h. (State) D.C.	
21. I certify that (this hospital) attended the deceased from July 3, 1961 to August 1, 1961 that (we) last saw the deceased alive on August 1, 1961 , and that death occurred at 12:57 AM from the causes and on the date stated above.			
22a. SIGNATURE W. Douglas Clark, M.D.		22b. DATE SIGNED 8/1/61	
22c. PHYSICIAN'S NAME (Type) W. Douglas Clark, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3 AUG. 1961	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION (City, town or county) WASHINGTON DC.	
24. FUNERAL DIRECTOR'S SIGNATURE Michael G. Rinaldi		24a. ADDRESS 816 H ST NE WASH. D.C.	
24b. DATE AUG 3 '61		24c. REGISTRAR'S SIGNATURE Arthur S. Rinaldi	



9269

CERTIFICATE OF DEATH

Reg. Dist. No. 09259

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>COLUMBIA</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 4 1X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1401 Tuckerman St NW</u>	
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>Payne</u> Last <u>Craft</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6, 1898</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Heroy Craft</u>		14. MOTHER'S MAIDEN NAME <u>Cora Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>578-07-6853</u>	
17. INFORMANT <u>Mrs. Barbara Nichols</u>		Address <u>938 Northampton Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma, left lung</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>metastases.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 17, 1961</u> , to <u>Aug 5, 1961</u> , that I last saw the deceased alive on <u>Aug 5, 1961</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1806 FOX ST.</u> DATE SIGNED <u>8/5/61</u> ACTUAL SIGNATURE <u>James H. Laubach</u> M.D. PHYSICIAN'S NAME (Type) <u>James H. Laubach</u> <u>Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/8/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove (Grove)</u>	22d. LOCATION (City, town, or county) (State) <u>Worcester, N. Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Biecher Sons</u> ADDRESS <u>Washington, D.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>Aug 8 '61</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

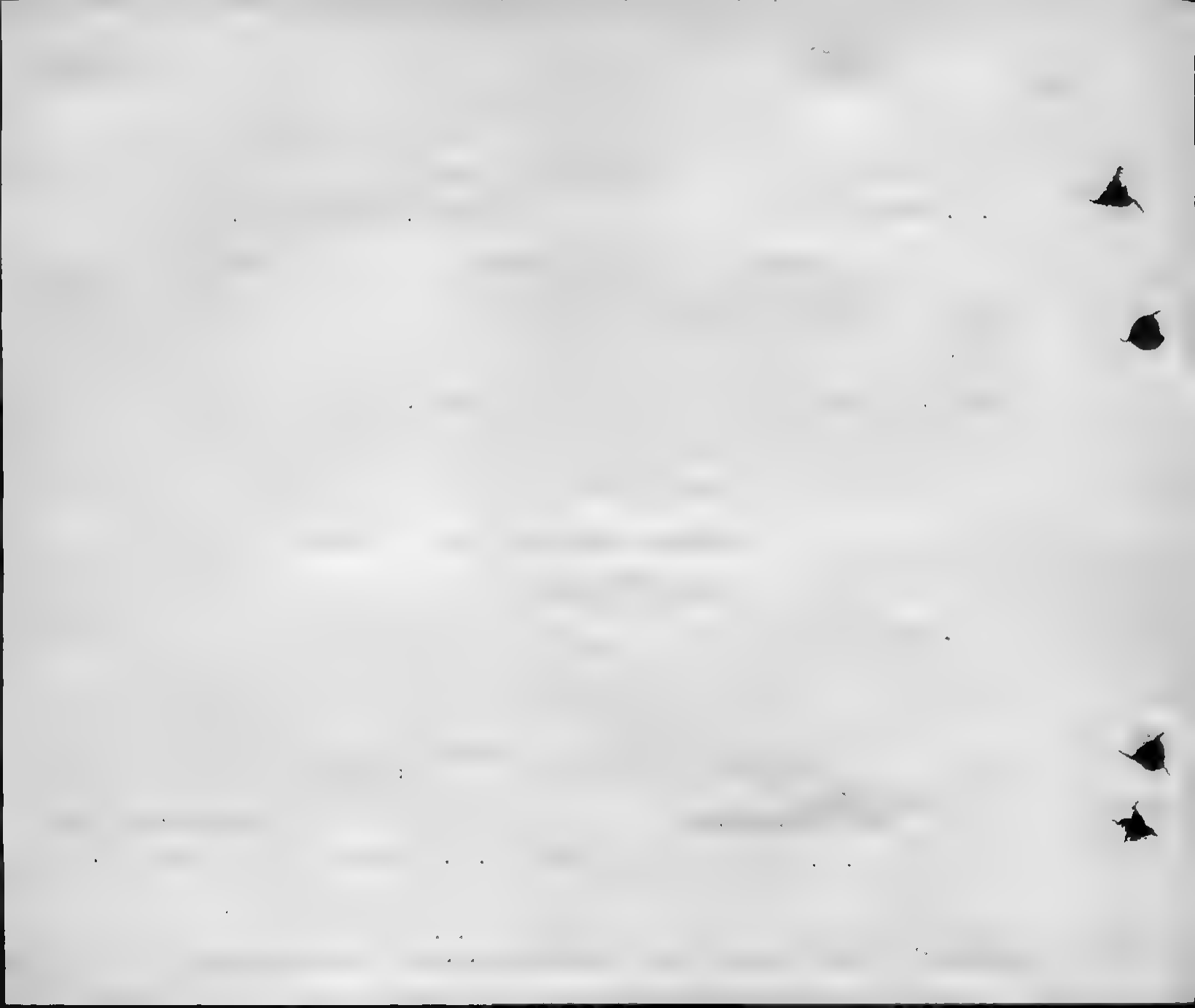
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9270											
CERTIFICATE OF DEATH											
Item 23 Film 0294 9/6/61 mb											
09260											
1. PLACE OF DEATH a. COUNTY Montgomery			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY in 1b 65 days			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Tennessee b. COUNTY Memphis c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1608 S. Lauderdale St.		
3. NAME OF DECEASED (Type or print) First Middle Last Laurie Renae Crawford			4. DATE OF DEATH Month Day Year August 28 19 61			5. SEX Female			6. COLOR OR RACE Negro		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 4-23-61			9. AGE (in years last birthday) yrs. 4 5			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Tennessee			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ellie L. Crawford			14. MOTHER'S MAIDEN NAME Rita J. Yates			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. Hospital Records		
17. INFORMANT Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MENINGITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INFECTED VENTRICULO ATRIAL SHUNT DUE TO (c) HYDROCEPHALUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) LARYNGO MALACIA			INTERVAL BETWEEN ONSET AND DEATH 41 DAYS 8 DAYS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (H) (this hospital) attended the deceased from June 24, 1961 to August 28, 1961, that (H) (we) last saw the deceased alive on August 28, 1961, and that death occurred at 4:00 AM, from the causes and on the date stated above.			22a. SIGNATURE R. W. MACKIE, CAPTAIN, MC, USN		
22b. DATE SIGNED August 28, 1961			22c. PHYSICIAN'S NAME (Type) R. W. MACKIE, CAPTAIN, MC, USN			22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, 23b. DATE THEREOF Removal (Specify) Burial-Shippment 30 August 1961			23c. NAME OF CEMETERY OR CREMATORY Unknown			23d. LOCATION (City, town or county) Memphis			23e. (State) Tennessee		
24. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home, 389 Rhode Island Ave. N.W.			24a. ADDRESS Washington, D.C.			24b. REC'D BY REGISTRAR AUG 30 '61			24c. REGISTRAR'S SIGNATURE Carlton L. Kline		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9271

CERTIFICATE OF DEATH

09261

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>3 HRS. 20 MIN.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LILLIAN</u> <u>SUE</u> <u>Crown</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1961</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 26, 1961</u>		9. AGE (In years last birthday) <u>3</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>3</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Crown</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Virginia Crown Wood</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____			
16. SOCIAL SECURITY NO. _____				17. INFORMATION <u>Hospital Records</u>				18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Apneustic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) _____							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____				20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>8-26</u> , 19 <u>61</u> , to <u>8-26</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-26</u> , 19 <u>61</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Lillian L. Leal</u>				22b. DATE SIGNED <u>8/28/61</u>				22c. PHYSICIAN'S NAME (Type) <u>L. I. Leal, M. D.</u>			
22d. ADDRESS <u>Gaithersburg, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>							
23b. DATE THEREOF <u>8-28-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>				23d. LOCATION (City, town or county) <u>Gaithersburg</u> (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Barber</u>				25a. REC'D BY REGISTRAR <u>SEP 1 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

20-3191 XV3

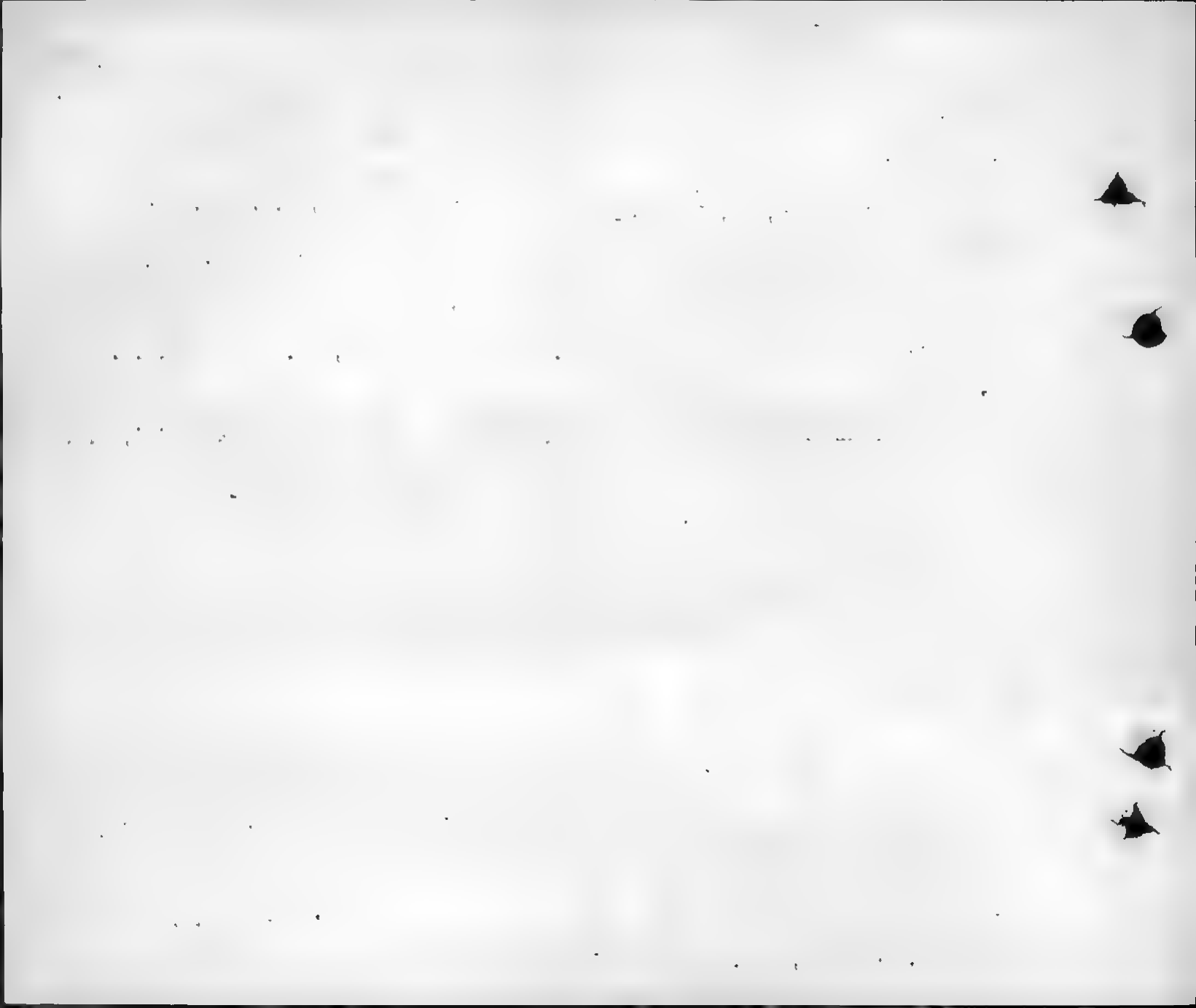


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9272 **CERTIFICATE OF DEATH**

Reg. Dist. No. **09262**

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 47x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Nursing Home, 14,511 Colesville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Herbert Last David				4. DATE OF DEATH Month August Day 7 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1876	
9. AGE (In years last birthday) 85 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Distributor		11. BIRTHPLACE (State or foreign country) Clarion County, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emil David				14. MOTHER'S MAIDEN NAME Sarah Bishop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No				16. SOCIAL SECURITY NO. Mr. Harold H. David			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Compensated heart failure with widespread infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 25, 1961</u> to <u>Aug 7, 1961</u> that I last saw the deceased alive on <u>Aug 7, 1961</u> and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u> ADDRESS (Street, city or town, state) <u>1919 Shinnery Road, Silver Spring, Md.</u> DATE SIGNED <u>Aug 9, 1961</u> PHYSICIAN'S NAME (Type) <u>Silver Spring Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/11/61		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u>				24a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc.		24b. REGISTRAR'S SIGNATURE <u>Aug 14 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

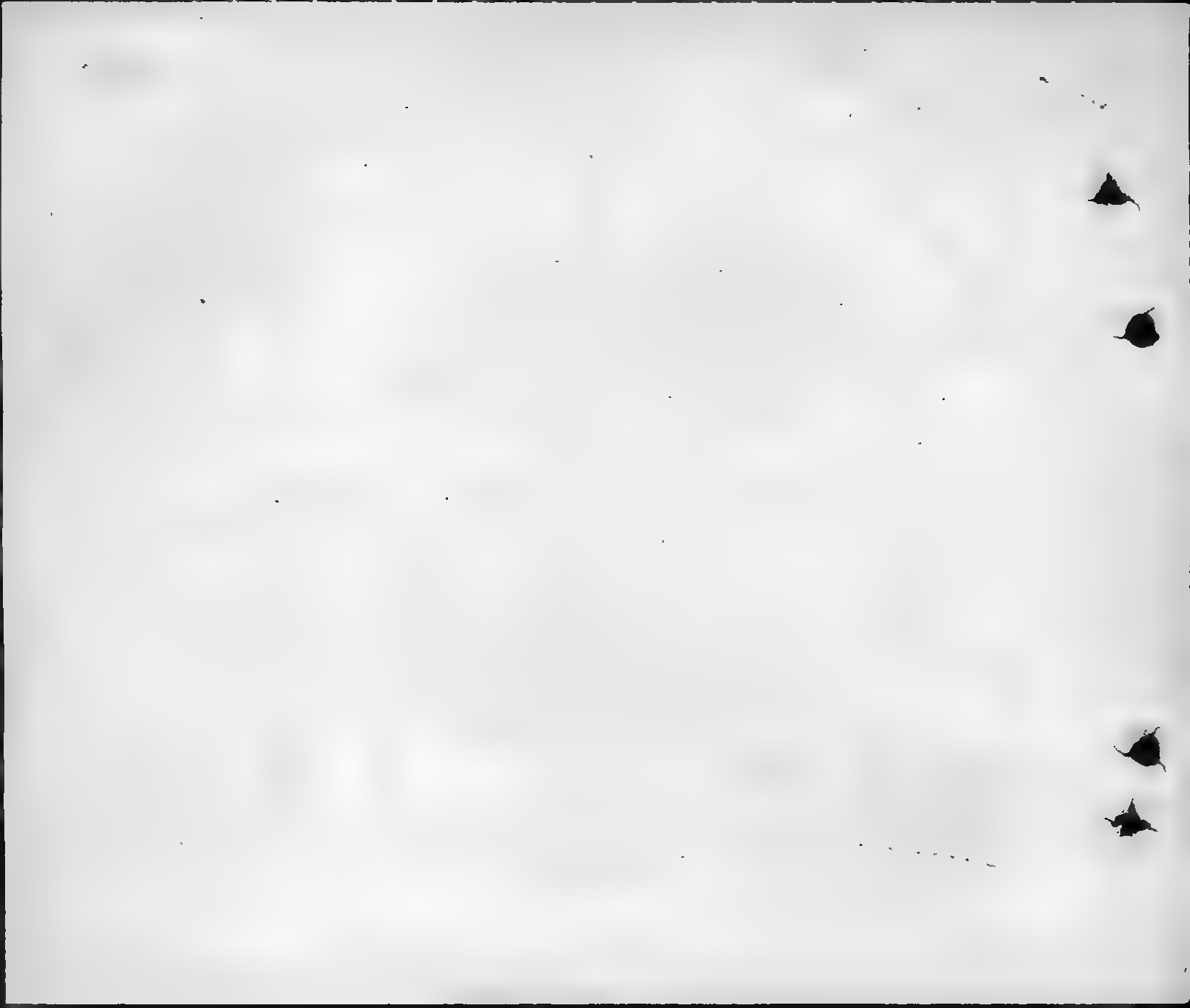


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VR A15 (4)
TSM 9/59

1
9273
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09263

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>md.</u> b COUNTY <u>Mont.</u>	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4507 Chase Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lena Elizabeth Day</u>		4. DATE OF DEATH Month Day Year <u>Aug. 26 1961</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8, 1886</u>
9 AGE (in years, lost b rthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min <u>7 12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Frances Todd</u>		14. MOTHER'S MAIDEN NAME <u>Florence Floyd</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>no</u>		16 SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>Dorothy Day / 5141 1/2 St / N. Bowie</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> DUE TO <u>cerebral thrombosis</u> Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>generalized arteriosclerosis</u> DUE TO (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>carcinoma of colon</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1961</u> to <u>Aug 26, 1961</u> that (II) (we) last saw the deceased alive on <u>August 28, 1961</u> and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard R. Ehrman</u> M.D.		22b. ADDRESS <u>4890 Battery Lane, Bethesda, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard R. Ehrman</u>		22d. ADDRESS <u>4890 Battery Lane, Bethesda, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/23/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 24 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

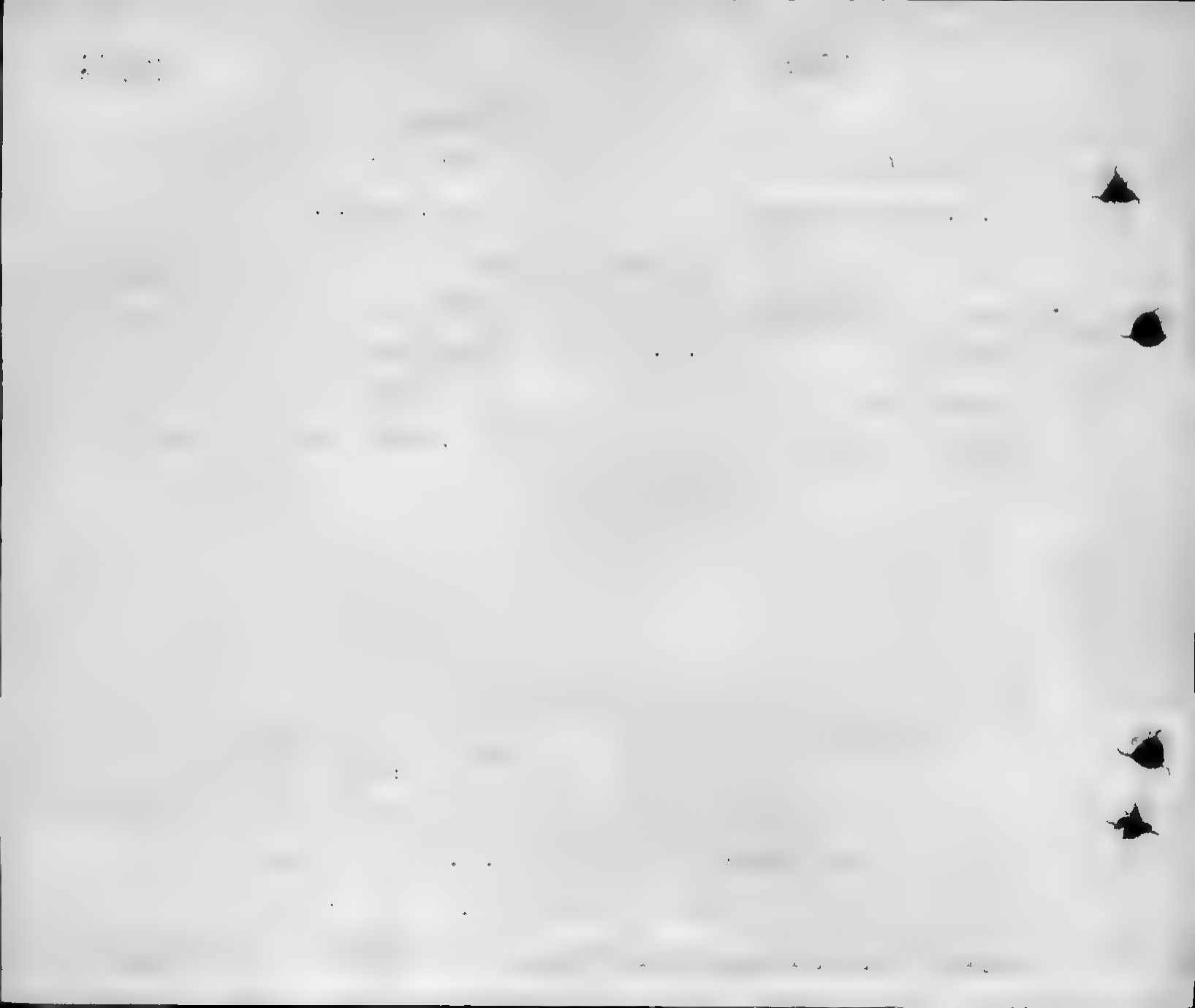


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9274
CERTIFICATE OF DEATH
09264

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. STREET ADDRESS 3130 Vally Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Leman Elroi Dehart		4. DATE OF DEATH Month Day Year August 12 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-10-88	
9. AGE (in years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James C. Dehart		14. MOTHER'S MAIDEN NAME Rebecca Jane Heckman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 17. INFORMANT Bertha S. Dehart Same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma pancreas - metastatic DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from August 5, 1961, to August 12, 1961, that (X) (we) last saw the deceased alive on August 12, 1961, and that death occurred at 9:10 PM, from the causes and on the date stated above.			
22a. SIGNATURE Bruce Harold Rice		22b. DATE SIGNED August 14, 1961	
22c. PHYSICIAN'S NAME (Type) BRUCE HAROLD RICE, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Humphrey		25a. REC'D BY REGISTRAR DATE AUG 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur J. Hantz			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

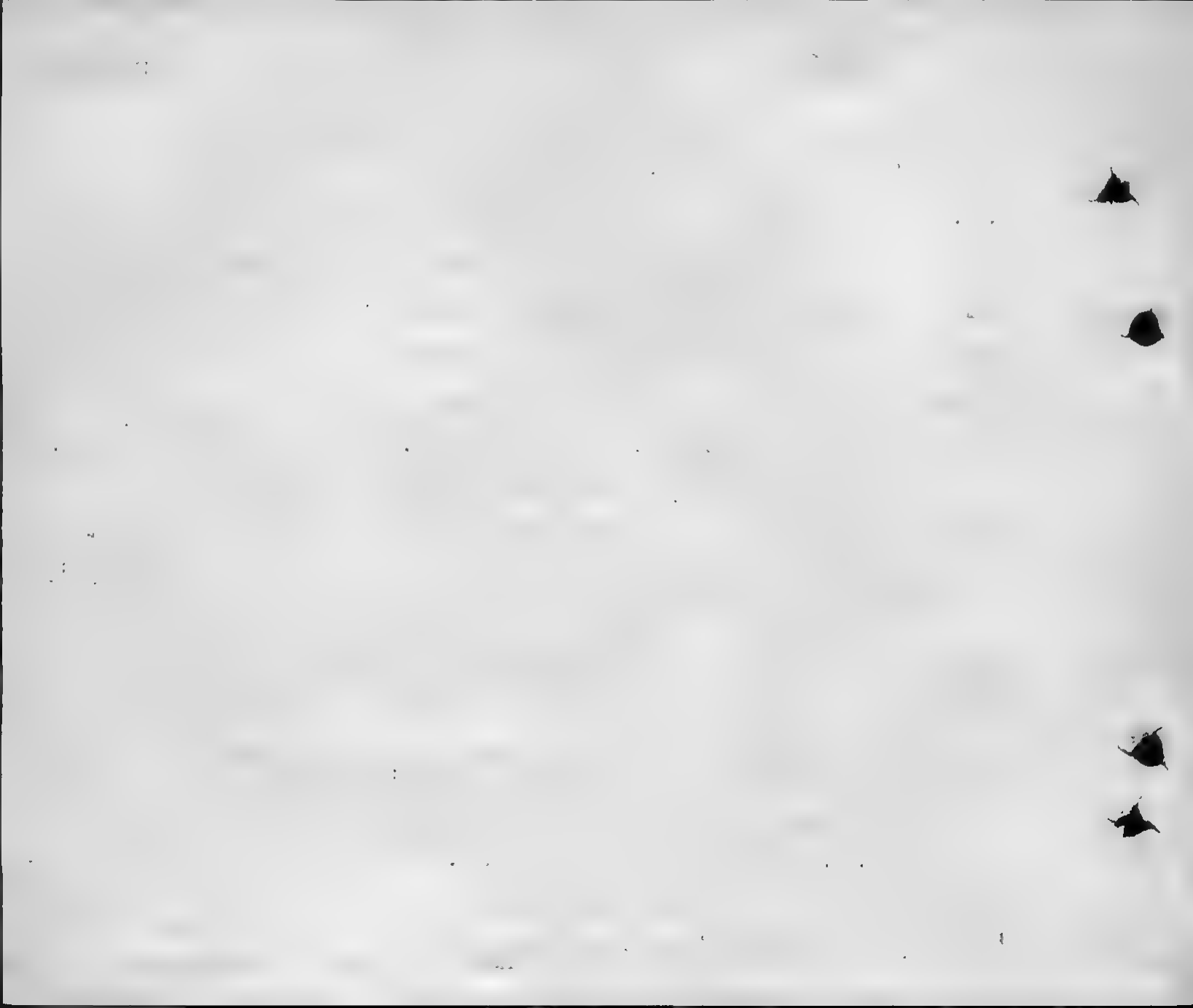
9275

CERTIFICATE OF DEATH

09265

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1754 Massachusetts Avenue	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN TB 2 Mo. - 6 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jacobus		4. DATE OF DEATH Last First Middle DIJKMAN August 18 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 22, 1900	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. 1 year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman		10b. KIND OF BUSINESS OR INDUSTRY Storage	
11. BIRTHPLACE (County & State or foreign country) HOLLAND		12. CITIZEN OF WHAT COUNTRY? HOLLAND	
13. FATHER'S NAME Unknown		14. MOTHER'S M maiden NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son) Robert O. DIJKMAN		Address 1754 Mass. Ave., Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transitional Cell Carcinoma of the bladder, with metastasis 179X (b) 179X (c) 179X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 12 June 1961 to 18 August 1961 that (I) saw the deceased alive on 18 August 1961 and that death occurred at 4:05 PM from the causes and on the date stated above.		22a. SIGNATURE L. N. CAHILL	
22b. PHYSICIAN'S NAME (Type) L. N. CAHILL, LCDR MC USN		22c. DATE SIGNED 20 August 1961	
22d. ADDRESS U. S. Naval Hospital, NNMC, Bethesda, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 22 Aug 1961	
23c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery		23d. LOCATION (City, town or county) (State) Talbot County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume		25c. ADDRESS 1557 Wisconsin Ave. Bethesda, Md.	

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9276

CERTIFICATE OF DEATH

09266

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN 1b 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney
d. STREET ADDRESS RED #1

3. NAME OF DECEASED (Type or print) Alice Brooke Dinwiddie
4. DATE OF DEATH August 26 1961
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH June 30, 1886
9. AGE (in years last birthday) 75 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Alban Brooke 14. MOTHER'S MAIDEN NAME Sarah Elizabeth Pleasants

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 218-34-7450 17. INFORMANT Hospital records

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction
(b) Coronary arteriosclerosis (marked)
(c) Cardiomegaly
DISEASE TO WHICH IMMEDIATE CAUSE (a) OR (b) OR (c) WAS RELATED TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year August 26 1961 20d. INJURY OCCURRED While ☒ Not While ☐ 20e. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) Medical Center, Sandy Spring, Md.
20f. (City or town) (County) (State)

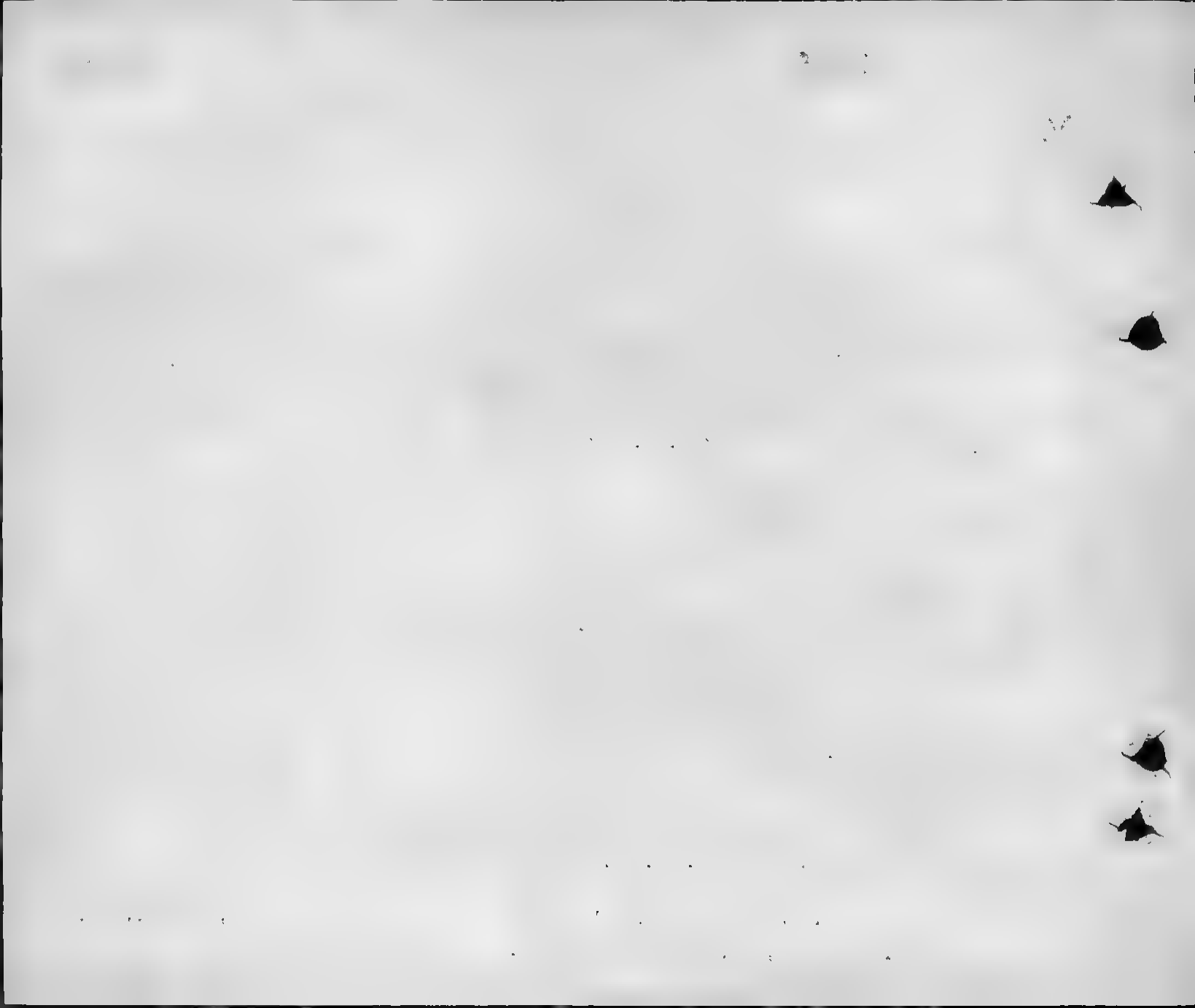
21. I certify that (I) (the hospital) attended the deceased from December 12, 1960 to 8/26, 1961, that (I) last saw the deceased alive on 8/26, 1961, and that death occurred at 12:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE J. P. Martin, M.D. 22b. DATE SIGNED 8/26/61
22c. PHYSICIAN'S NAME (Type) J. P. Martin, M.D. 22d. ADDRESS Medical Center, Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Aug. 29, 1961 23c. NAME OF CEMETERY OR CREMATORY Friends' Cemetery 23d. LOCATION (City, town or county) (State) Sandy Spring, Montg., Md.

24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC., SILVER SPRING, MD. 25a. REC'D BY REGISTRAR DATE AUG 30 '61 25b. REGISTRAR'S SIGNATURE John S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9277

CERTIFICATE OF DEATH

09267

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>31 Oxford St.,</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>V.</u> Last <u>Dolan</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>16</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/29/03</u>	9. AGE (In years last birthday) <u>58</u> Yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Gaylordville, Conn.</u>	
13. FATHER'S NAME <u>Albert Dolan</u>				14. MOTHER'S MAIDEN NAME <u>Alice Roach</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>wife, Philomena Dolan</u>				Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse, postoperative</u> DUE TO <u>Bronchogenic Carcinoma with extensive metastasis, unresectable</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>6 months +</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> <u>1961</u> to <u>Aug 16</u> <u>1961</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>Aug 16</u> <u>1961</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. D. Peabody Jr.</u>				22b. DATE SIGNED <u>Aug 16, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. D. Peabody Jr.</u>				22d. ADDRESS <u>1150 Conn. Ave. Wash. D.C.</u>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>8/19/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>AUG 21 '61</u>			
ADDRESS <u>Bethesda, Maryland</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

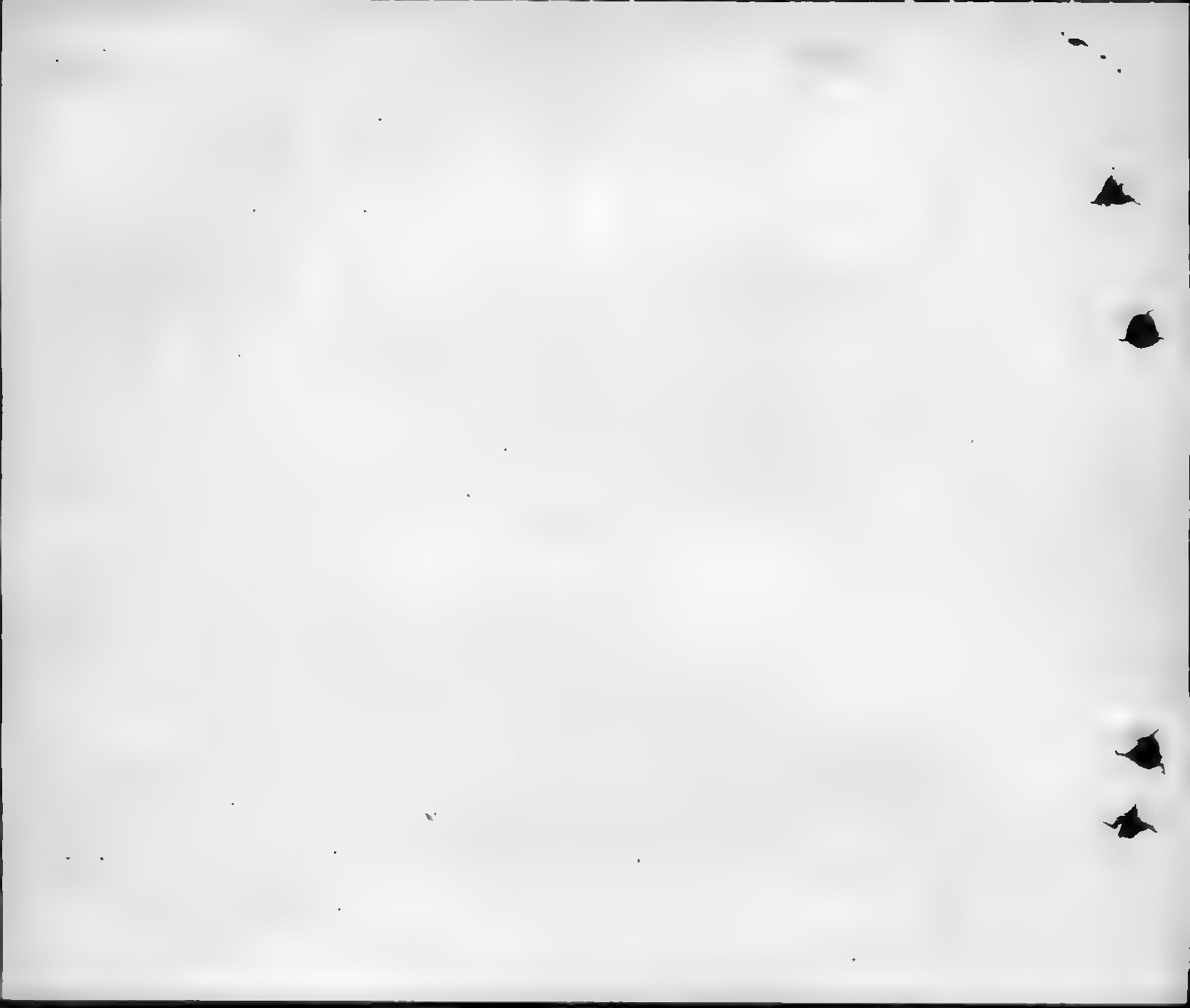
9278

09269

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				d. STREET ADDRESS 2901 Conn. Avenue, N. W.			
3. NAME OF DECEASED (Type or print) First Kathryn Middle E Last Dunkhorst				4. DATE OF DEATH Month August Day 14 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/1877	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 9 Days 12	IF UNDER 24 HRS Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Dunkhorst				14. MOTHER'S MAIDEN NAME Elizabeth Fuss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Dowell-Granddaughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bowel Obstruction 104X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA of Rectum DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 70 days 2 YRS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 28 1949 to Aug 14 1961 , that (I) (we) last saw the deceased alive on Aug 13 1961 , and that death occurred at 4:30 M, from the causes and on the date stated above.							
22a. SIGNATURE Horace H. Curtis, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 8-14-61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Horace H. Curtis, Jr.				22d. ADDRESS 1822 1852 Columbia Road NW, Wash. D.C.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/17/61		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		23d. LOCATION (City town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR AUG 18 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

M

I



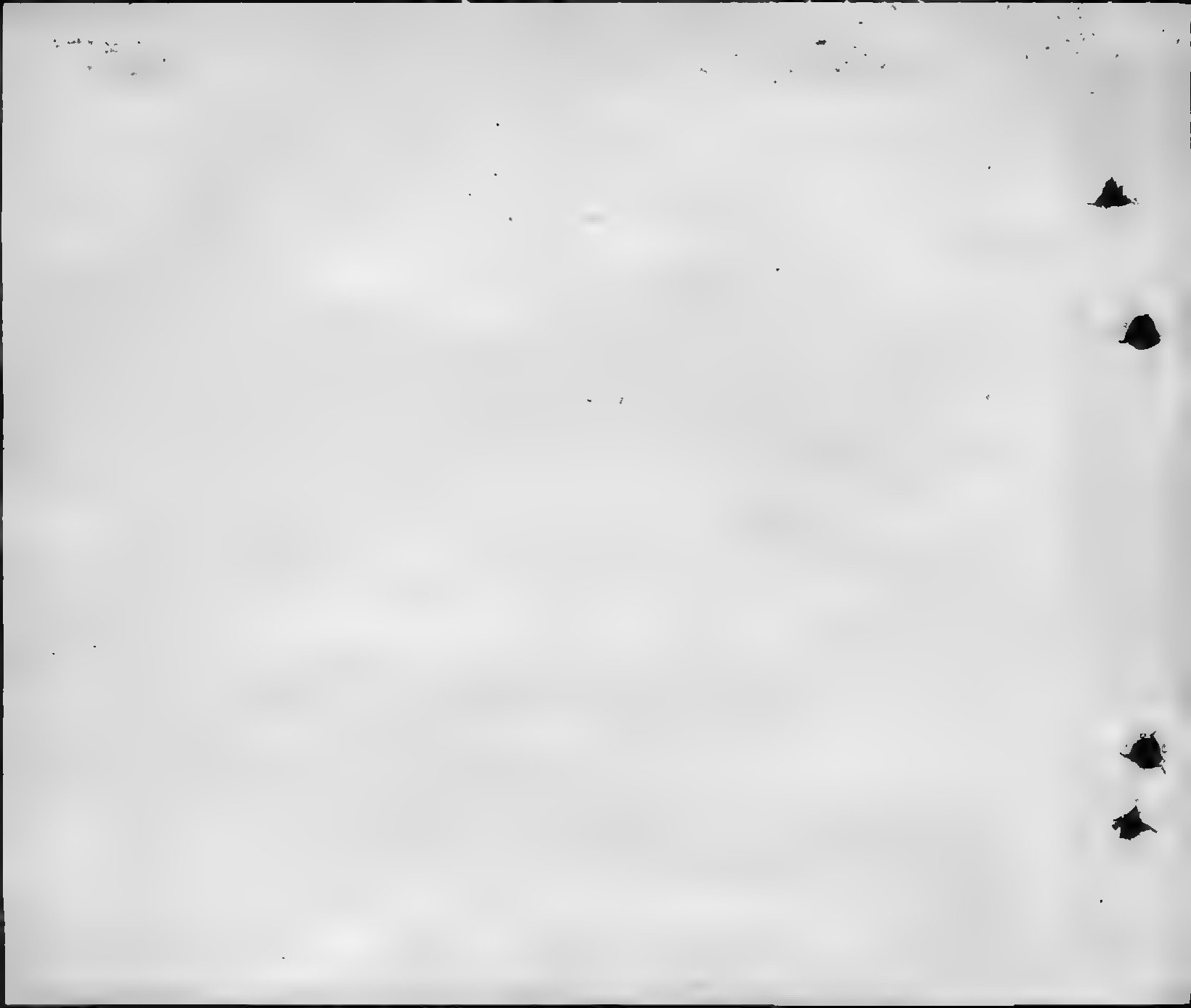
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09270

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN It <u>37 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5601 Chillum Hgts Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard Lewis Edwards Jr.</u>		4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator D.C. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard L. Edward Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. II</u>	
17. INFORMANT <u>Ruby Sweatman-Sister in law</u>		Address <u>Same Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 421 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/5/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Kalley's Funeral Home, Inc.</u>		ADDRESS <u>mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	



9280

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09271

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 90 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Summit c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Summit d. STREET ADDRESS 27 Sheffield Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Reed Last Edwards		4. DATE OF DEATH Month August Day 22 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1927
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 34 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contracting Engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor Edwards		14. MOTHER'S MAIDEN NAME Lena Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes If yes, give war or dates of service WWII		16. SOCIAL SECURITY NO 423-26-4747	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia with acute blastic crisis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 24, 1961 to August 22, 1961 , that I last saw the deceased alive on August 22, 1961 and that death occurred at 12:49 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED August 28, 1961			
ACTUAL SIGNATURE Geo. H. Porter		M.D. George H. Porter, M.D.	
PHYSICIAN'S NAME (Type) GEORGE H. PORTER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 8/23/61		22b. DATE THEREOF 8/23/61	
22c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		22d. LOCATION (City, town, or county) Birmingham, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 28 61		24b. REGISTRAR'S SIGNATURE Arthur J. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

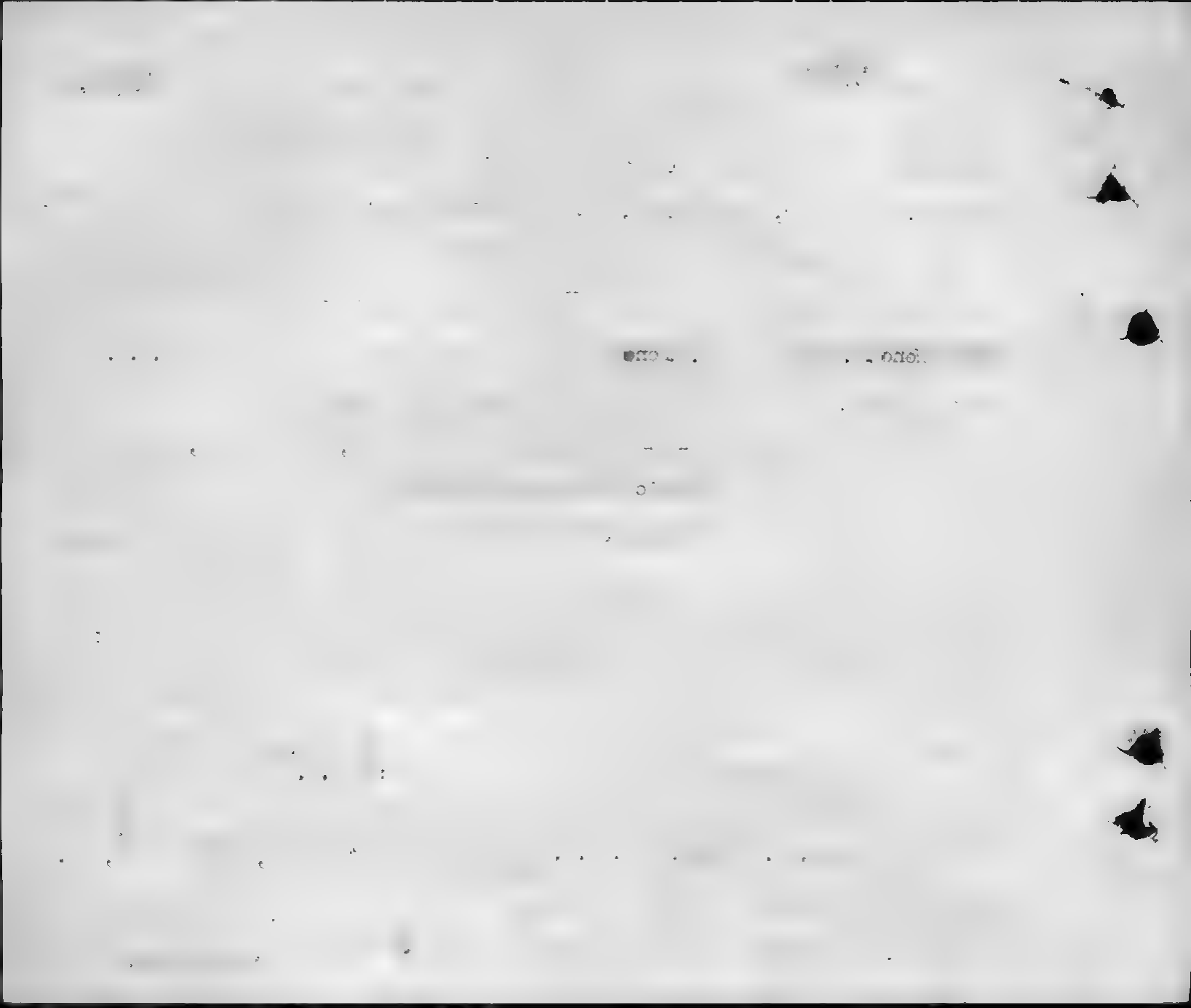
CERTIFICATE OF DEATH

9281

09272

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Union c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2051 Pleasant Parkway d. STREET ADDRESS 2051 Pleasant Parkway	
3. NAME OF DECEASED (Type or print) Paul Robert Eskin		4. DATE OF DEATH Month August Day 13 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1941	
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.) last birthday Months Days Hours Min. 19 yrs.		10. USUAL OCCUPATION (Give kind of work done) None	
10a. USUAL OCCUPATION (Give kind of work done) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE County & State or foreign country New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Eskin		14. MOTHER'S MAIDEN NAME Helen Eroncrantz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1959 - 1960		16. SOCIAL SECURITY NO. 138-32-7299	
17. INFORMATION The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia DUE TO (b) Congestive Heart Failure DUE TO (c) 	
19. INTERVAL BETWEEN ONSET AND DEATH 21 months		20. INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 28, 1961, to August 13, 1961, that (I) (we) last saw the deceased alive on August 13, 1961, and that death occurred at 10:20 p.m. from causes and on the date stated above.		22a. SIGNATURE GEO. H. PORTER, III, M.D.	
22b. PHYSICIAN'S NAME (Type) GEO. H. PORTER, III, M.D.		22c. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans 8/14/61		23b. DATE THEREOF 8/14/61	
23c. NAME OF CEMETERY OR CREMATORY Hebrew Cemetery		23d. LOCATION (City, town or county) (State) Newark, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE AUG 16 '61	
Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9282

09273

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

MARYLAND

c. LENGTH OF STAY (in days)

60 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

New York

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Flushing

d. STREET ADDRESS

141-49 70th Road, Kew Garden Hills

e. IS RESIDENCE

ON FARM?

☐ NO ☒ YES

3. NAME OF DECEASED (Type or print)

First

Benjamin

Middle

Harold

Last

Ezrin

4. DATE OF DEATH

Month

August

Day

12

Year

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

July 28, 1896

9. AGE (in years last birthday)

65 yrs.

IF UNDER 1 YEAR, OF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Store Owner

10b. KIND OF BUSINESS OR INDUSTRY

Business

11. BIRTHPLACE (Country & State, or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Max Ezrin

14. MOTHER'S MAIDEN NAME

Anna Zirlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give order details of service)

Yes

WW I

051-14-1610

16. SOCIAL SECURITY NO. 17. INFORMANT

The Medical Record

The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Terminal Cardiac Arrhythmia & Acute Renal Shutdown

INTERVAL BETWEEN ONSET AND DEATH

1 day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO

Carcinoid Heart Disease

(b)

Malignant Carcinoid with

DUE TO

Hepatic & Peritoneal Metastasis

(c)

? 1 year

? 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMAL DISEASE CONDITION GIVEN IN PART I(a)

Arteriosclerosis & Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

21. I certify that (this hospital) attended the deceased from June 13, 1961 to August 12, 1961, that (we) last saw the deceased alive on August 12, 1961, and that death occurred at 1:10 PM from the causes and on the date stated above.

22a. SIGNATURE

O. Wesley McBride

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

8/12/61

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

O. Wesley McBride, M.D.

22d. ADDRESS

The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, or other disposal (Specify)

BURIAL

23b. DATE THEREOF

8/15/61

23c. NAME OF CEMETERY OR CREMATORY

Cedar Park

23d. LOCATION (City, town or county)

Paramus, New Jersey

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

ADDRESS

Bethesda, Md.

25a. DATE BY REGISTRAR

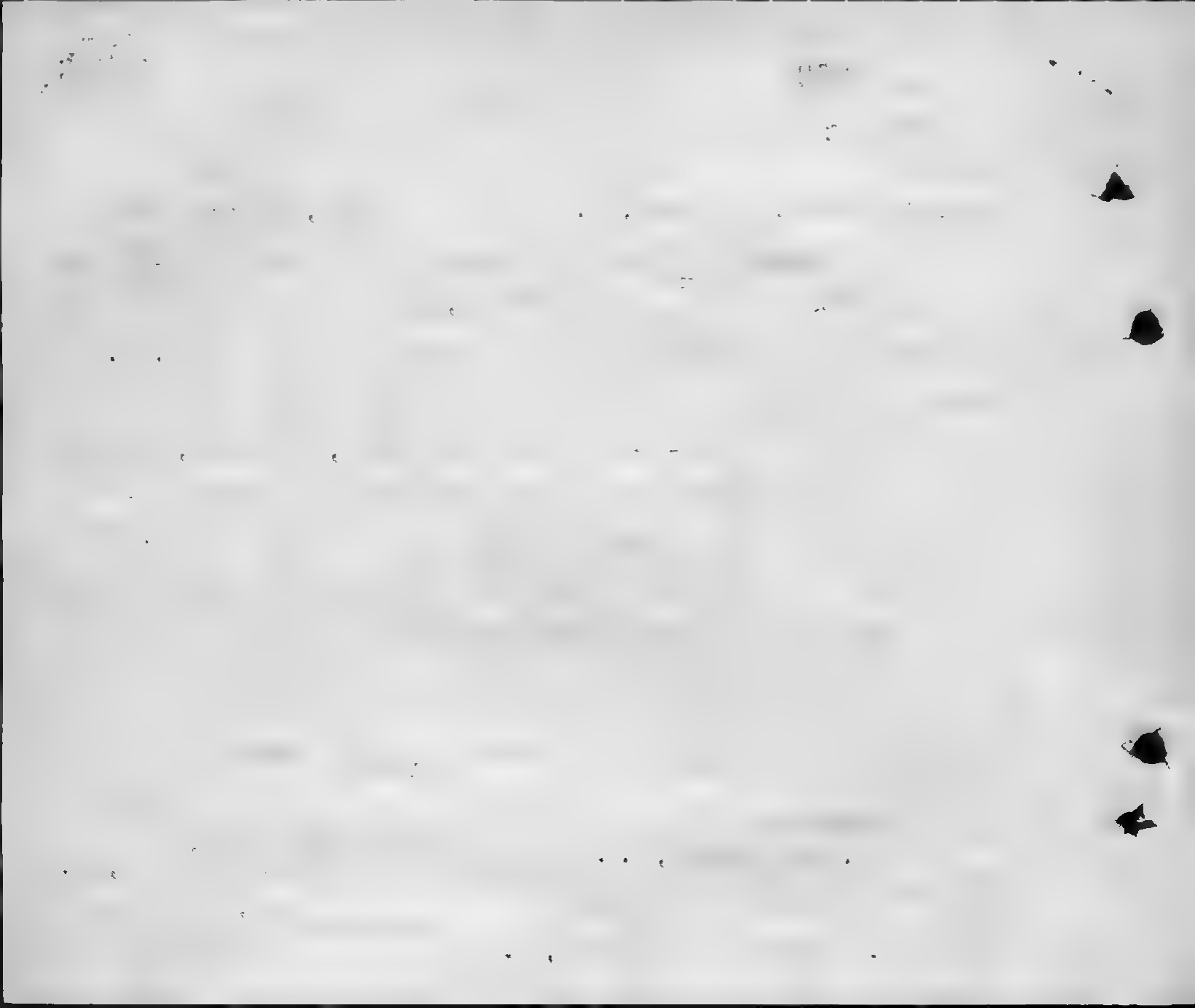
AUG 16 1961

25b. REGISTRAR'S SIGNATURE

Arthur S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled out by the funeral director. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

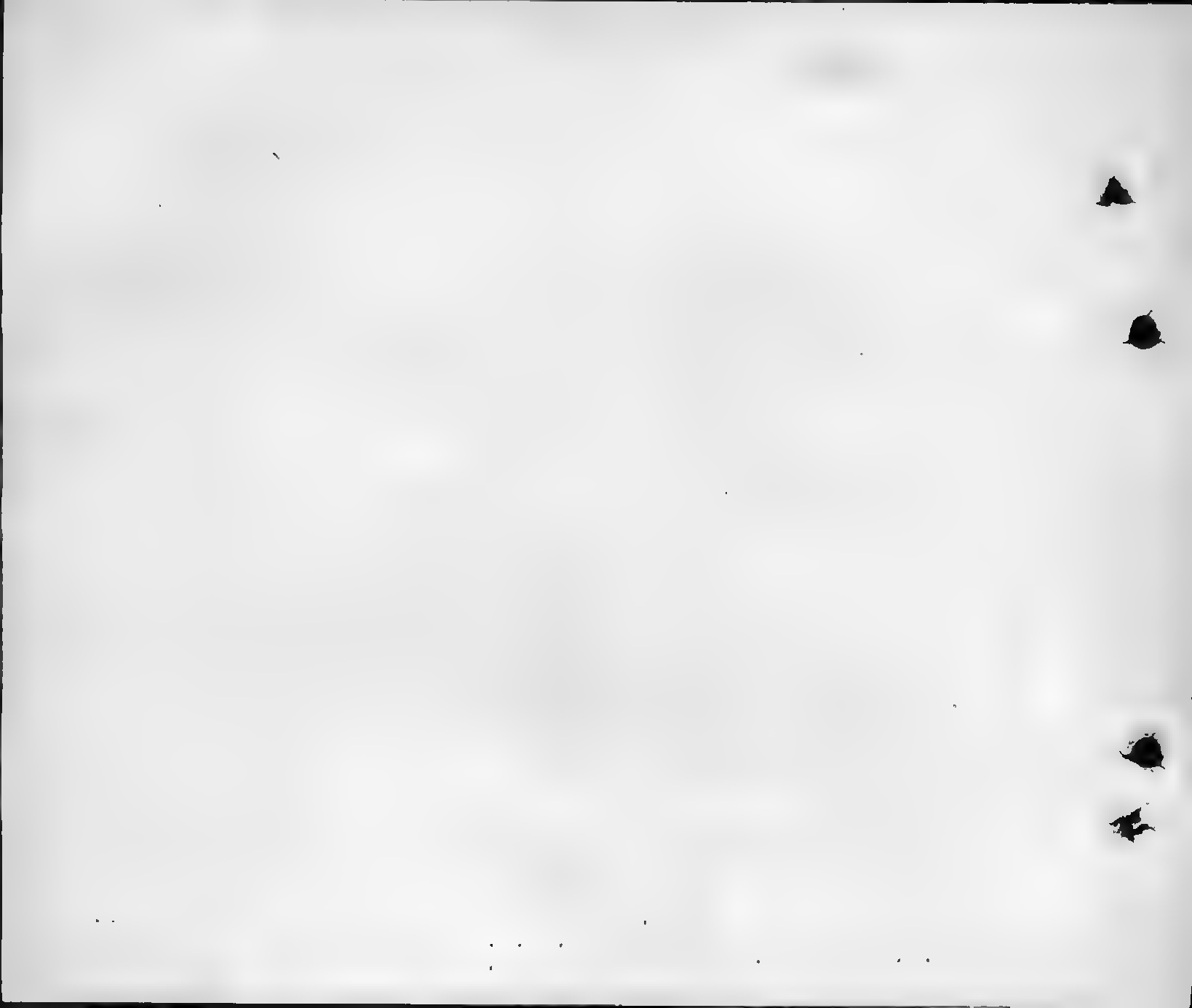
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09274

9283

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>32 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>		d. STREET ADDRESS <u>1500-MASS. AVE. N.W.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARGARET A.</u> Middle <u>F.</u> Last <u>Feldt</u>		4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1/90</u>
9. AGE (In years lost birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <u>Nurse and Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>BUFFALO, N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>MR. NAT. C. HODGSON</u> Address <u>7501 N. HOLIDAY TERRACE, BETHESDA, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post Prosthesis Right Hip (Subcapital Fracture)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I. or Part I. of item 18) <u>Fracture of Hip from fall Wash DC</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>April 21/1961</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u> </u> of work <u> </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Wash DC</u>	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> to <u>Aug 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 28, 1961</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. I. S. GRISOFF</u>		22d. ADDRESS <u>4500 Conn Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation 8/31/61</u>		23b. DATE THEREOF <u>8/31/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th St. N.W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Washington 9, D.C.</u>		25c. DATE <u>AUG 30 61</u>	

(M)
090
(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MONTGOMERY COUNTY				MONTGOMERY COUNTY			
1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10808 BREEWOOD RD.				d. STREET ADDRESS 10808 BREEWOOD RD.			
3. NAME OF DECEASED (Type or print) FRANK				4. DATE OF DEATH AUGUST 10 1961			
5. SEX MALE				6. COLOR OR RACE WHITE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>				8. DATE OF BIRTH APRIL 22, 1976			
9. AGE (In years last birthday) 85 yrs.				10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0			
11. BIRTHPLACE (County & State, or foreign country) ITALY				12. CITIZEN OF WHAT COUNTRY? 1st PAPERS, USA.			
13. FATHER'S NAME GIUSEPPE FERRARA				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO			
17. INFORMANT ALEX FERRARA				Address 10808 BREEWOOD RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (b) 2+ yrs (c) PLEURISY - 5 WEEKS PREVIOUSLY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PLEURISY - 5 WEEKS PREVIOUSLY				INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from AUG. 10, 1961 to AUG. 10, 1961 , that (I) (the) last saw the deceased alive on AUG. 10, 1961 , and that death occurred at 5:15 PM from the causes and on the date stated above.				22a. SIGNATURE Gene U. Cohen M.D.			
22b. DATE AUG. 10, 1961				22c. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.			
22d. ADDRESS 931 PERSHING DR., SILVER SPRING				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 8/14/61			
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION (City, town or county) Montgomery County, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR AUG 16 '61			
25b. REGISTRAR'S SIGNATURE Arthur E. Kline				25c. REGISTRAR'S SIGNATURE			



S285

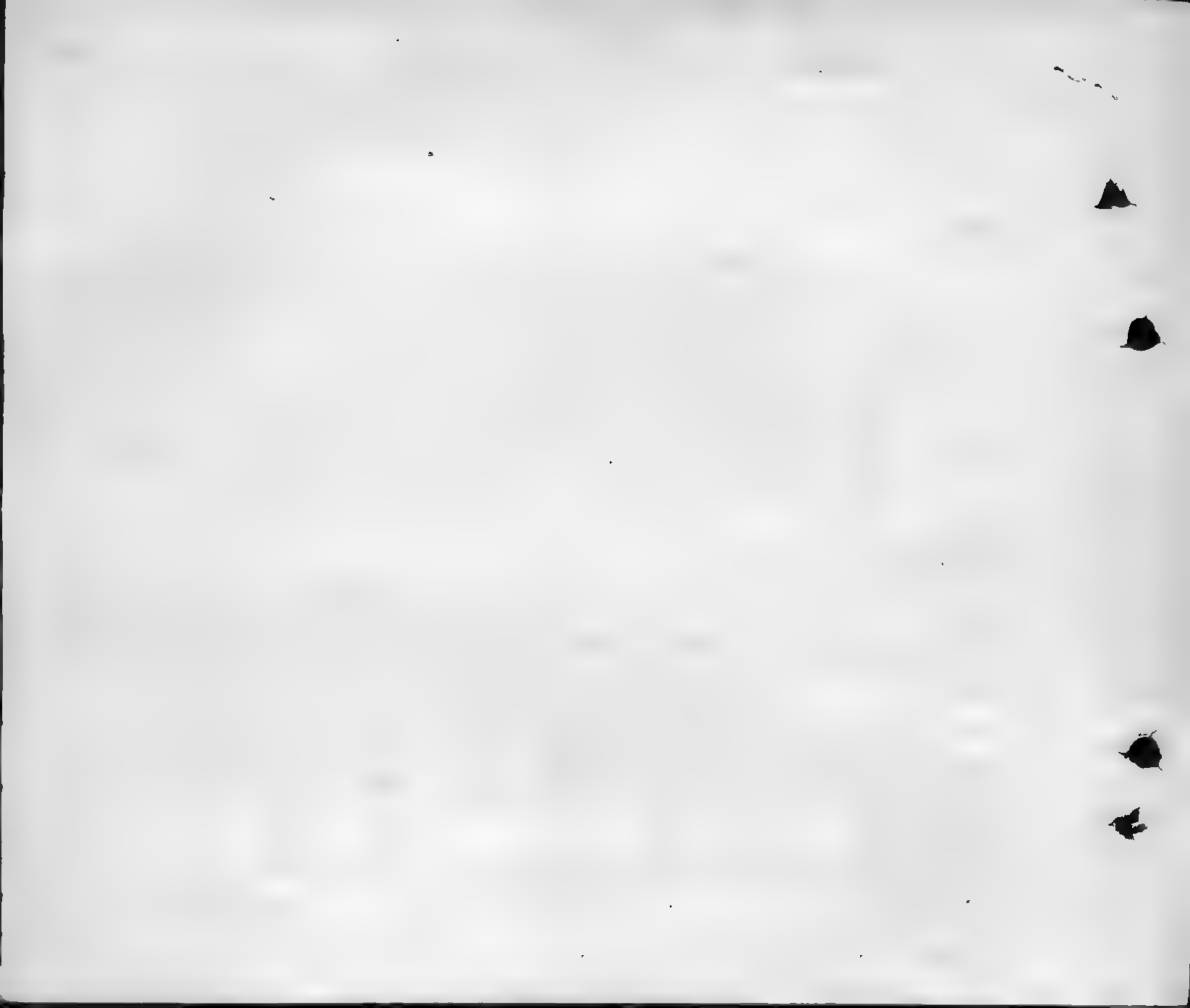
CERTIFICATE OF DEATH

Reg. Dist. No. 09276

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium				d. STREET ADDRESS 5915 Sonoma Road			
3. NAME OF DECEASED (Type or print) First Arthur Middle W. Last FERRIN				4. DATE OF DEATH Month 8 Day 10 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/63	
9. AGE (In years last birthday) 98 yrs.		IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 3 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Unknown) Ferrin				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-18-8580		17. INFORMANT John A. Carlson-Friend-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NATURAL CAUSES 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8/8 , 19 61 , to 8/10 , 19 61 , that I last saw the deceased alive on 8/9 , 19 61 , and that death occurred at 2:45 PM , from the causes and on the date stated above							
ACTUAL SIGNATURE I. L. Marks				ADDRESS (Street, city or town, state) 6306 Wisconsin Ave DATE SIGNED 8/10/61			
PHYSICIAN'S NAME (Type) I. L. MARKS				Chase 15, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/16/61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR AUG 18 '61	
				24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

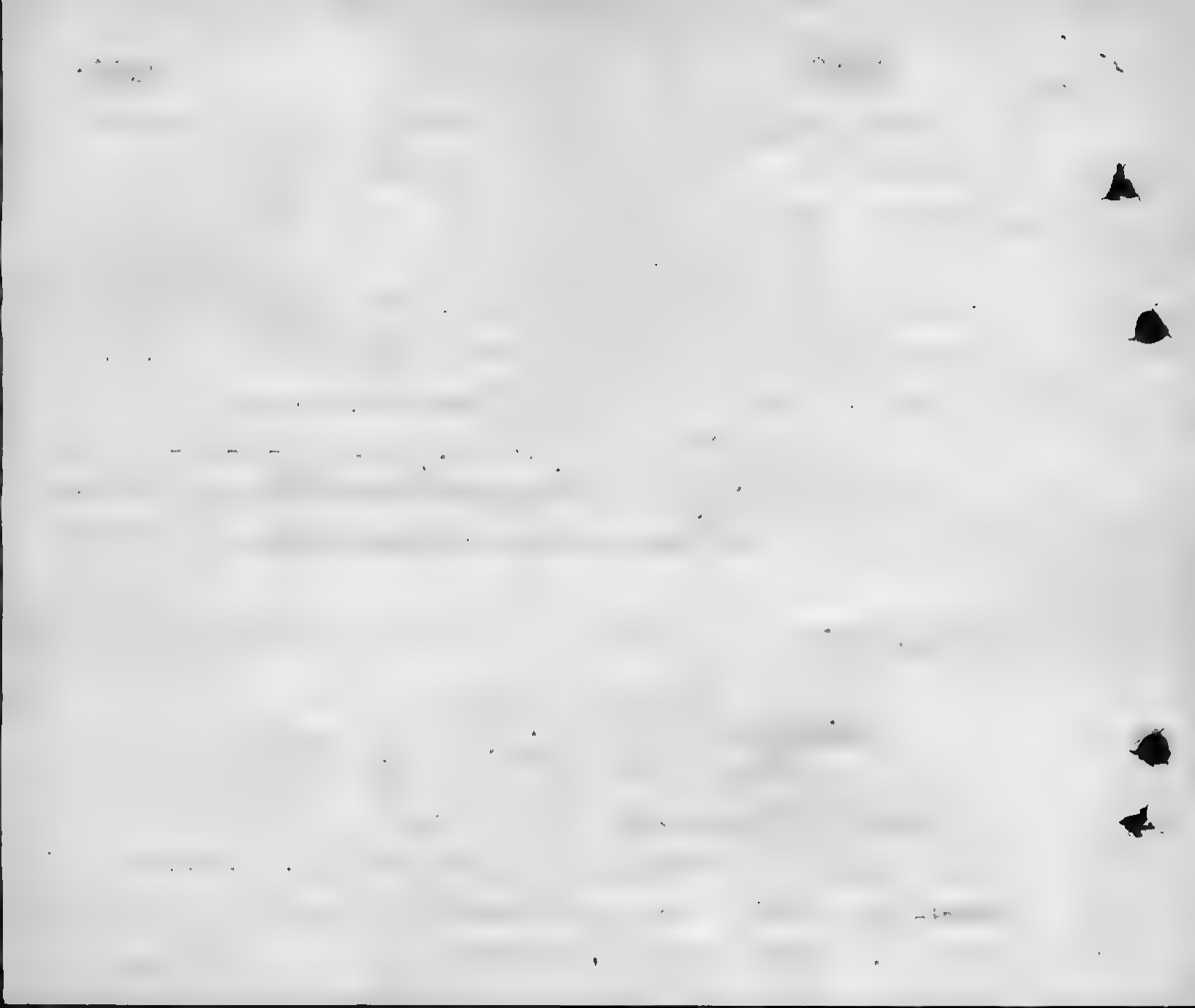
CERTIFICATE OF DEATH

9286

09277

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (For out of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 7606 Arnet Lane d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7606 Arnet Lane		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 7606 Arnet Lane					
3. NAME OF DECEASED (Type or print) ROSE H. FLINT		4. DATE OF DEATH Month August Day 28 Year 1961					
5. SEX Female		6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1883					
9. AGE (In years last birthday) 78 yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days Hours Min</td> <td>Months Days Hours Min</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days Hours Min	Months Days Hours Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days Hours Min	Months Days Hours Min						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Newport, Rhode Island					
11. BIRTHPLACE County & State, or foreign country U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME Joseph F. Howard		14. MOTHER'S MAIDEN NAME Adelaide Kenworthy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None					
17. INFORMANT 1 John L. Hoen, sone-in-law-same 2d		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis (myocardial infarction) (b) Arteriosclerosis Generalized (c) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis - Coronary Arteriosclerosis - Cleared by X-Ray PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis - Coronary Arteriosclerosis - Cleared by X-Ray					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) NO		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerosis - Coronary Arteriosclerosis - Cleared by X-Ray					
20c. TIME OF INJURY Month, Day, Year Hour 5:28 p.m.		20d. INJURY OCCURRED June 5, 1961 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Washington, D.C. (County) D.C. (State) D.C.					
21. I certify that (I) (the hospital) attended the deceased from June 5, 1961, to 8/28/61, 1961, that (I) (we) last saw the deceased alive on 8/27, 1961, and that death occurred at 3:30 p.m. from the causes and on the date stated above.							
22a. SIGNATURE John B. Markobsky		22b. DATE SIGNED 8-28-61					
22c. PHYSICIAN'S NAME (Type, print) John B. Markobsky		22d. ADDRESS 4545 Conn. Ave., N.W., Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans 8/30/61		23b. DATE THEREOF 8/30/61					
23c. NAME OF CEMETERY OR CREMATORY Swan Point Cemetery		23d. LOCATION (City, town or county) (State) Providence, Rhode Island					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR SEP 1 '61					
25b. REGISTRAR'S SIGNATURE Bethesda, Maryland		25c. REGISTRAR'S SIGNATURE Arthur L. Hines					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

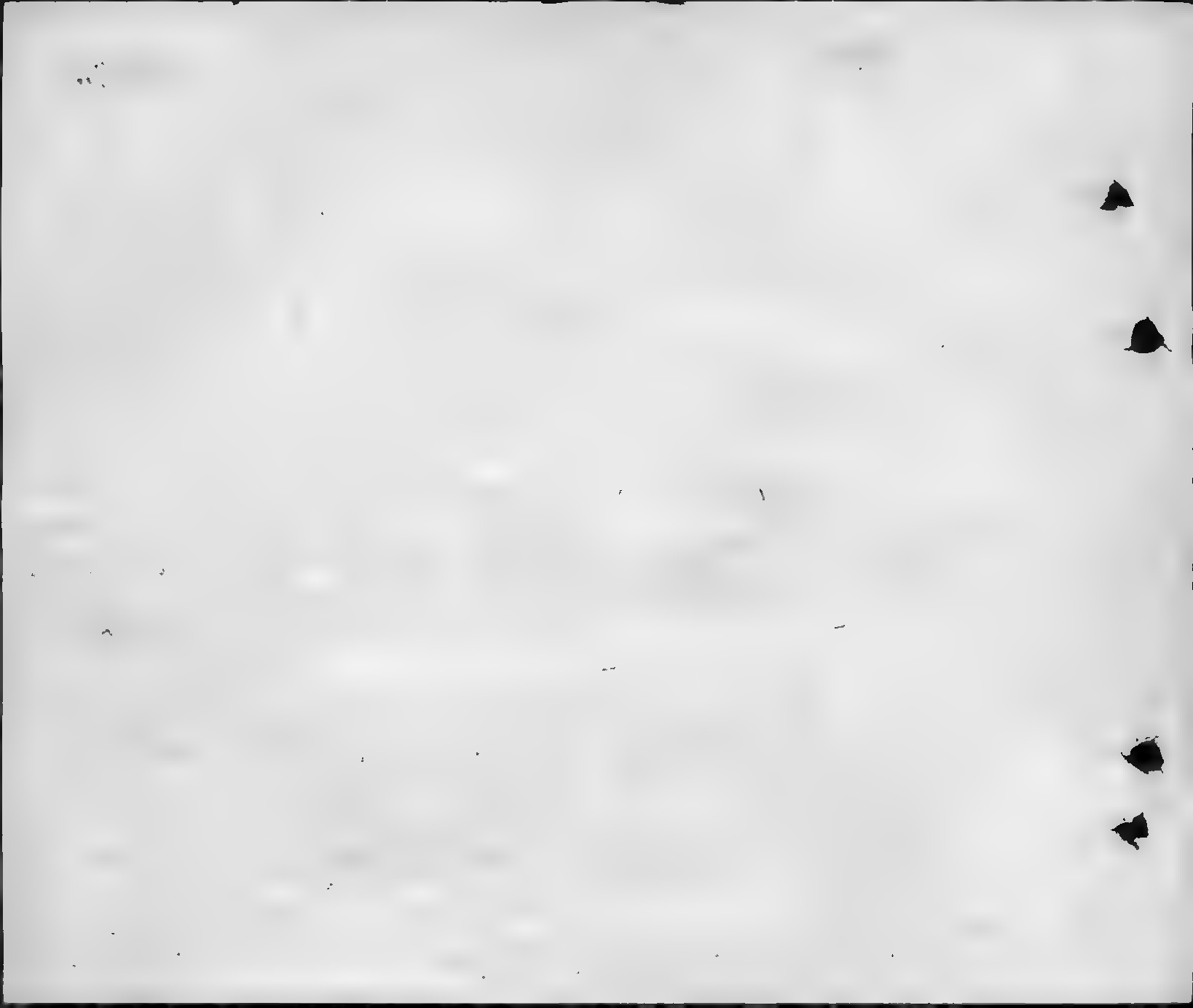
9287

09278

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> d. STREET ADDRESS <u>3202 Kimberly Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Type or print <u>Dorothy Elizabeth Fones</u>		4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-3-24</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>36</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary & Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>J. H. Malseed</u> 14. MOTHER'S MAIDEN NAME <u>Alice Borum</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> 16. SOCIAL SECURITY NO. <u>1577-26-4217</u> 17. INFORMANT <u>and old Hosp. records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis & Insufficiency - Severe</u> (b) <u>Bilateral Hydrothorax & Ascites</u> (c) <u>Carcinoma Breast right & generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs. 7 days about 6 mos.</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 7, 1961</u> to <u>8-15, 1961</u> , that (I) (we) last saw the deceased alive on <u>8-15, 1961</u> and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Read N. Calvert, M.D.</u> 22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type) <u>Read N. Calvert, M.D.</u> 22d. ADDRESS <u>909 Pershing Drive, Silver Spring, Md.</u>	
23a. BURIAL OR CREMATION <u> </u> 23b. DATE THEREOF <u>8/18/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> 23d. LOCATION (City, town or county) <u>Arlington, Virginia</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> 25a. RECEIVED BY REGISTRAR <u>AUG 21 1961</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunsell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

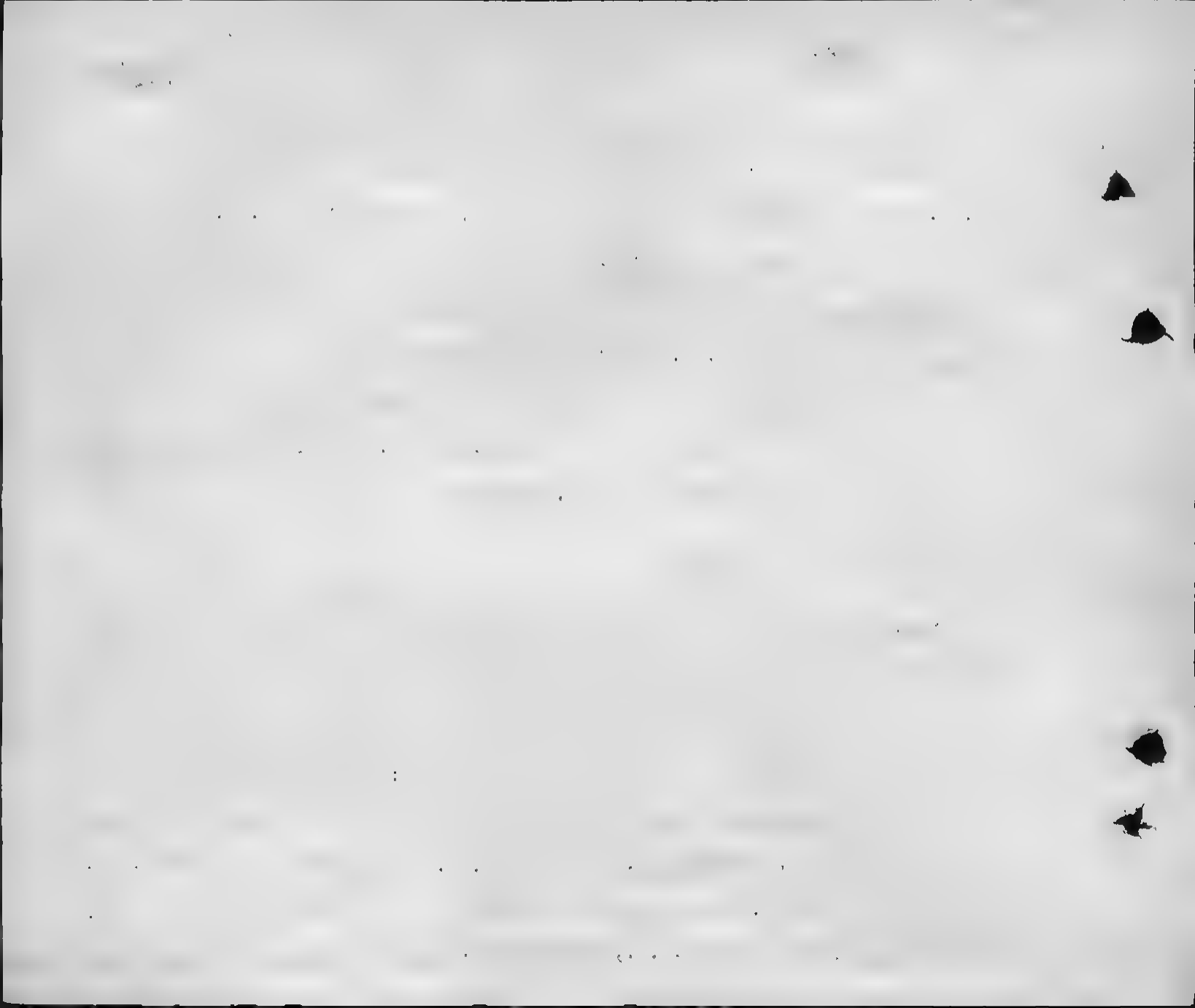
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9288

CERTIFICATE OF DEATH

09279

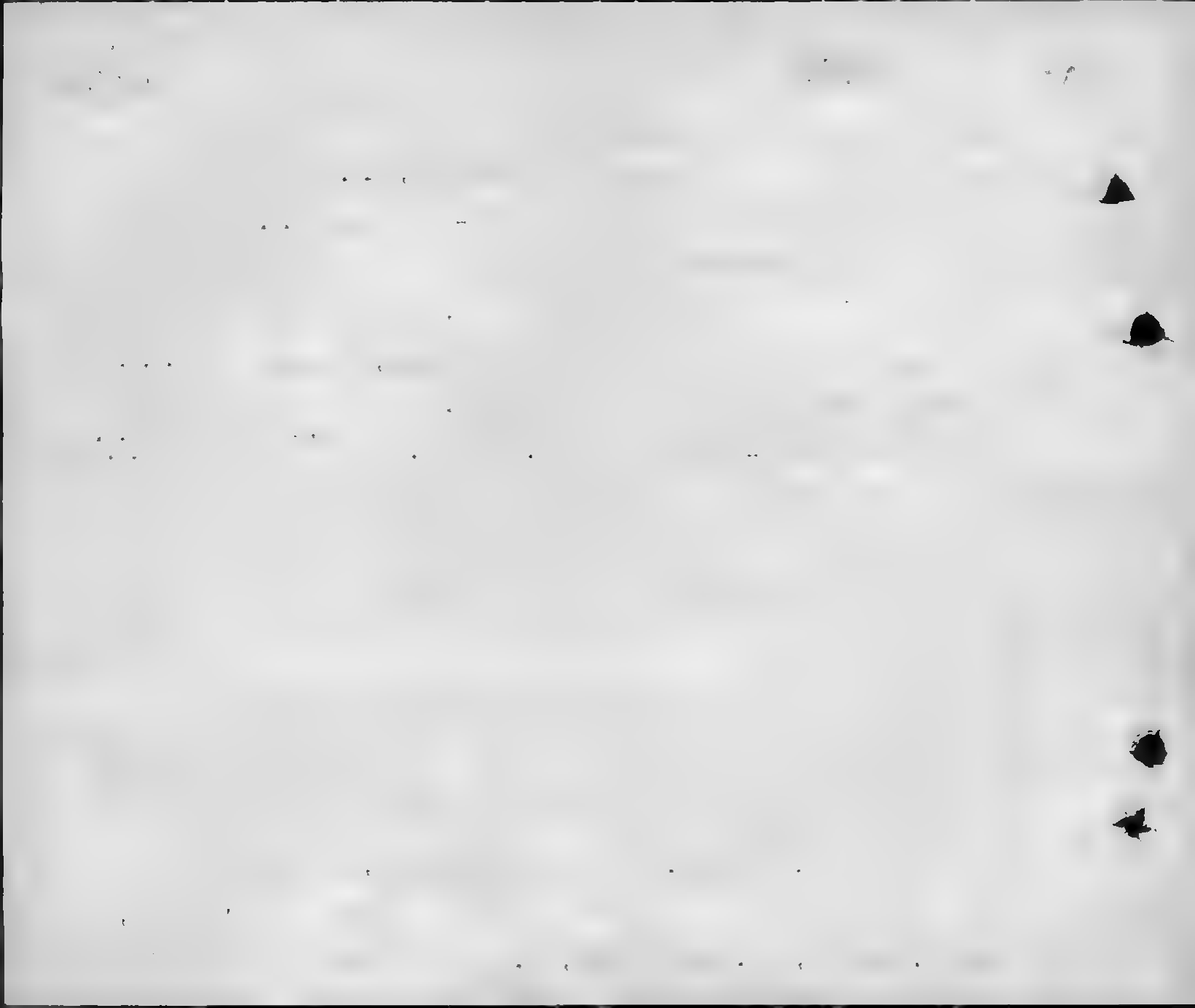
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 36 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5367 Blaine Street, N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Benjamin Jerome Fonville		4. DATE OF DEATH August 25 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analytic statistician		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	11. BIRTHPLACE (County & State, or foreign country) North Carolina
13. FATHER'S NAME Benjamin S. Fonville		14. MOTHER'S MAIDEN NAME Lillian Holden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. [blank]	
17. INFORMANT (W) Mrs. Olga V. Fonville same as #2 above		Address [blank]	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X Hodgkins Disease DUE TO (b) [blank] Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) [blank]		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pneumonia			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) [blank]	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. [blank] 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [blank]	20f. (City or town) (County) (State) [blank]
21. I certify that (this hospital) attended the deceased from July 20, 1961 to August 25, 1961, that (X) (we) last saw the deceased alive on August 25, 1961, and that death occurred at 12:00 PM from the causes and on the date stated above.			
22a. SIGNATURE John W. Brackett, Jr. 22c. PHYSICIAN'S NAME (Type) JOHN W. BRACKETT, JR. LT MC USN		22b. DATE SIGNED August 25, 1961 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington Va.
24. FUNERAL DIRECTOR'S SIGNATURE Stewart Funeral Home, 30 H St. N.E., Washington, D.C.		25a. REC'D BY REGISTRAR AUG 29 '61	25b. REGISTRAR'S SIGNATURE Arthur S. [blank]



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SE Coroner Notified and approved (M) 8/21/61

TWO STAR STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
9288			
CERTIFICATE OF DEATH			
09280			
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 7001 - 31st Street N.W.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ednor		c. LENGTH OF STAY IN IN Two months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Belmont Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Elizabeth Foright		4. DATE OF DEATH Month August Day 21 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1876	
9. AGE, in years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday Months Days Hours Mins. 85 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
11. KIND OF BUSINESS OR INDUSTRY Own Home		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Edmonson		14. MOTHER'S MAIDEN NAME Kopkinsville, Kentucky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Evelyn M. Shah	
17. INFORMANT Mary E. Thacker		Address 7001 - 31st Street N.W. Washington D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Recurrent (post operative) left breast carcinoma DUE TO Conditions (any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture right hip (6/6) with open reduction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH uncomplicated	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) uncomplicated	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/19		20f. (City or town) 8/21	
20g. (County) 1961		20h. (State) 1961	
21. I certify that (I) (this hospital) attended the deceased from 6/19 to 8/21 , 19 61 , that (I) (we) last saw the deceased alive on 8/5 , 19 61 , and that death occurred at 4 M., from the causes and on the date stated above			
22a. SIGNATURE John P. Martin MD.		22b. DATE SIGNED 8/21/61	
22c. PHYSICIAN'S NAME (Type) JOHN P. MARTIN MD.		22d. ADDRESS Sandyspring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/23/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Prince George's County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DATE AUG 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. ADDRESS 8434 Georgia Avenue Silver Spring, Md.	



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MARYLAND STATE DEPARTMENT OF HEALTH

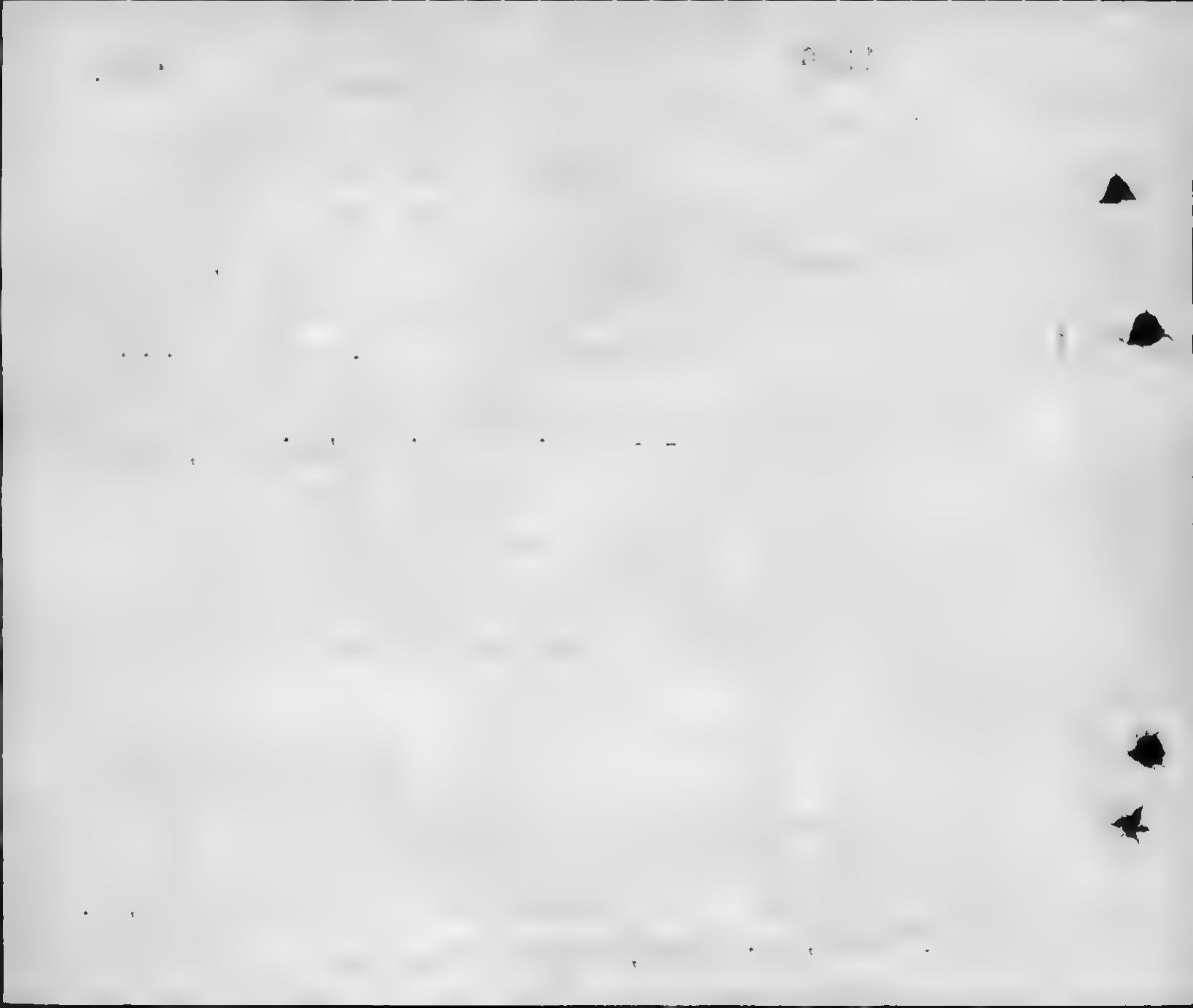
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9290

CERTIFICATE OF DEATH

09281

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if instit on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium & Hospital</u>		e. STREET ADDRESS <u>7906 Woodbury Drive</u>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND CLIFTON FREAS, SR.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Male</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>2</u> Hours <u>1</u> M. n.	
6. COLOR OR RACE <u>White</u>		10. DATE OF BIRTH <u>12-7-98</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. PLACE OF BIRTH (Country & State, or foreign country) <u>Montgomery Co., Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Allen Freas</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hayes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>Mr. Raymond C. Freas, Jr.</u>	
16. SOCIAL SECURITY NO. <u>214-03-8610</u>		Address <u>2936 Marlow Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 322X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerosis</u> (c) <u>Arterio-sclerosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.	
20c. TIME OF INJURY Month <u>8</u> Day <u>5</u> Year <u>1961</u> Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/5</u> 19 <u>61</u> to <u>8/8</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/8</u> 19 <u>61</u> , and that death occurred at <u>2:38</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. B. Little</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE</u>		22d. ADDRESS <u>6911 5th St. N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/11/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>AUG 11 '61</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Krens</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

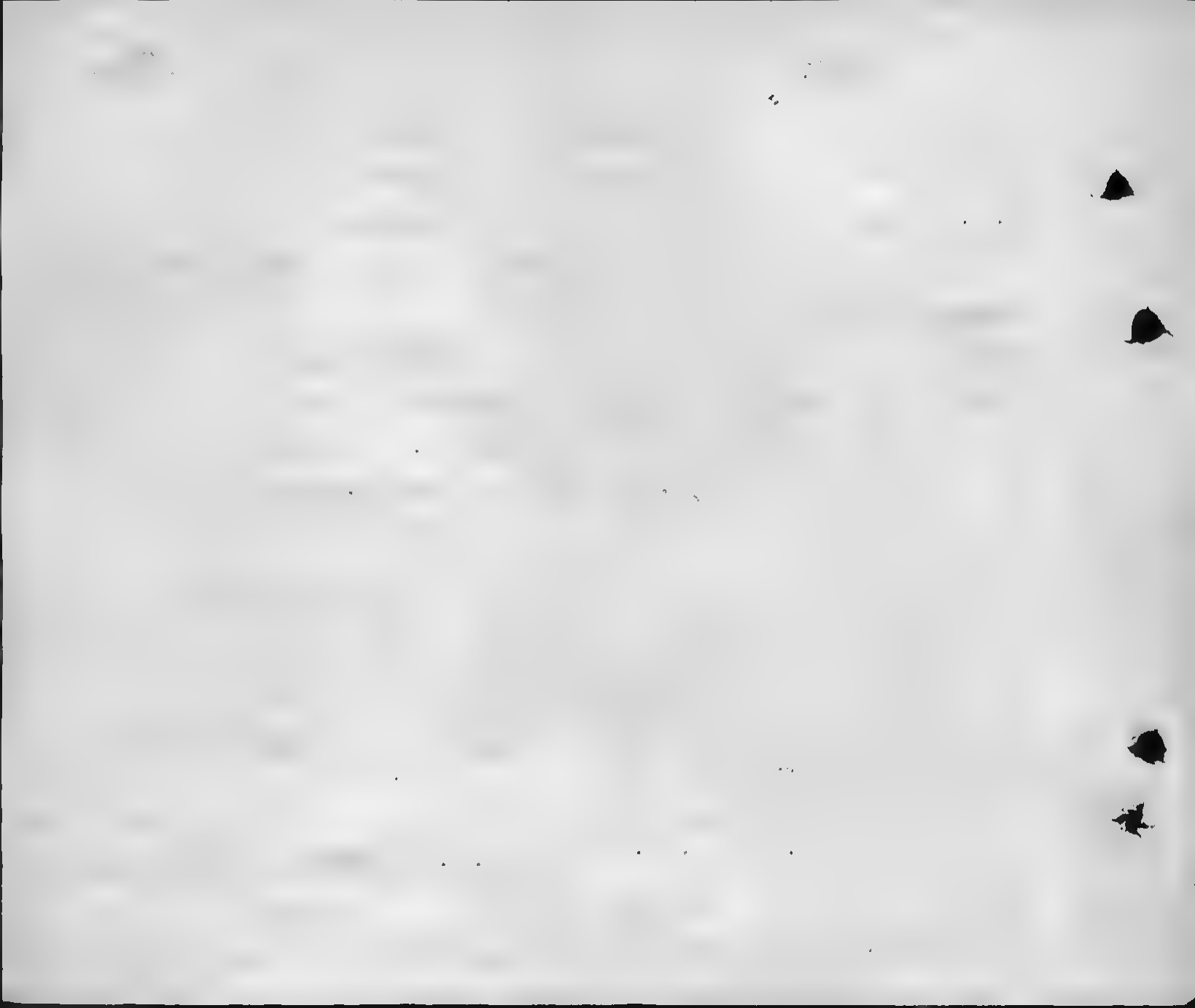
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09282

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>719 Monroe St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GARGES</u> 5. SEX <u>Unknown</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-8-61</u> 9. AGE (in years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		4. DATE OF DEATH <u>August 10 1961</u> 13. FATHER'S NAME <u>Daniel Tyler Garges</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Ann Duncan</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO <u>(F) Daniel T. Garges same as #2 above</u> 17. INFORMANT <u>(F) Daniel T. Garges same as #2 above</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MULTIPLE CONGENITAL ANOMALIES</u> 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>August 8 1961</u> Hour a.m. <u>7:22</u> p.m. <u>AM</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Arlington</u> (County) <u>Va</u> (State) <u>Va</u> 21. I certify that (X) (this hospital) attended the deceased from <u>August 8 1961</u> to <u>August 10 1961</u> that (X) (we) last saw the deceased alive on <u>August 10 1961</u> and that death occurred at <u>7:22 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>James J. Ryskamp, Jr.</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JAMES J. RYSKAMP, JR. LT MC USN</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u> 22e. DATE SIGNED <u>August 10, 1961</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>August 15, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>Va</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>Rockville</u> 25a. REC'D BY REGISTRAR <u>AUG 11 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9292

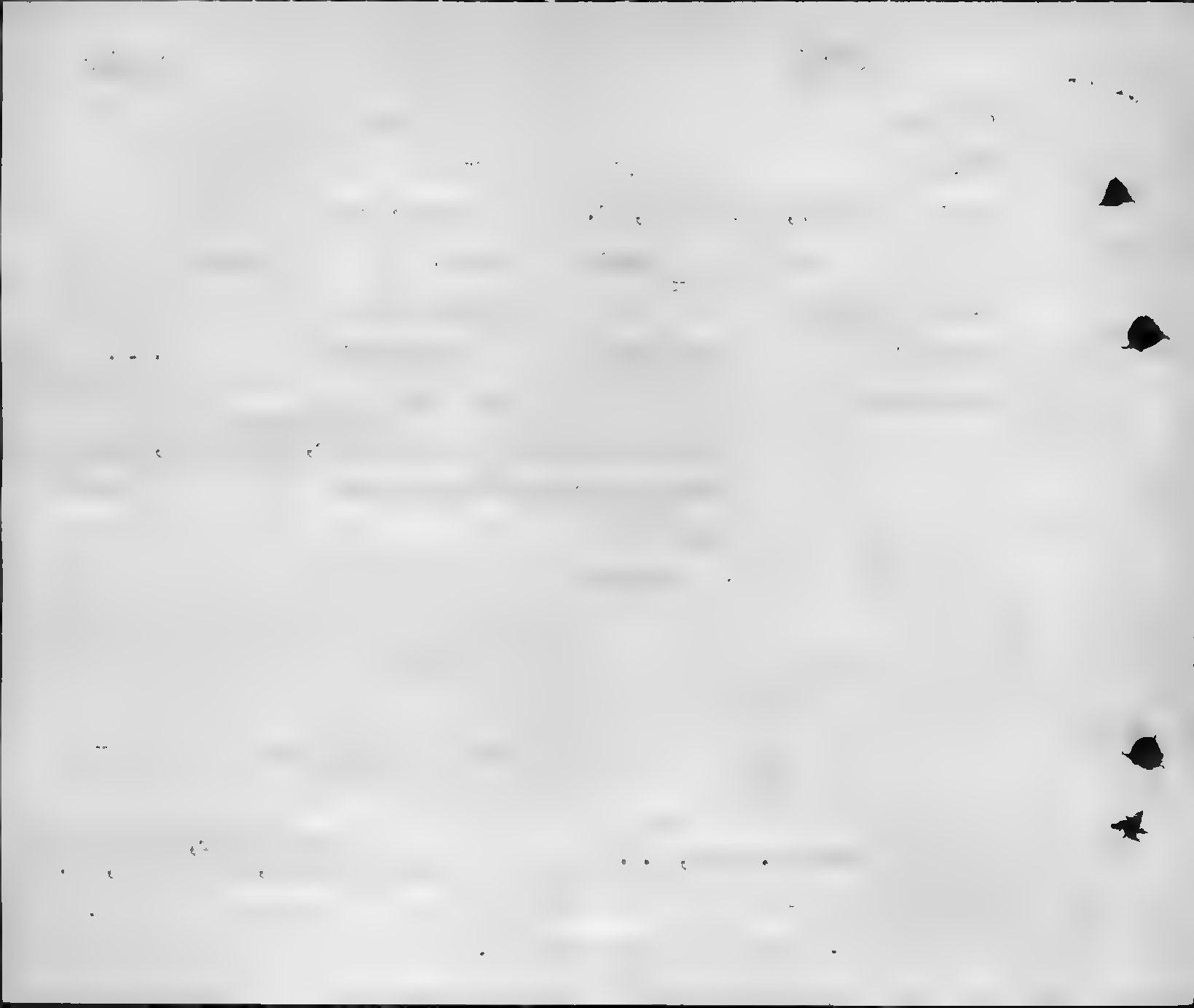
CERTIFICATE OF DEATH

09283

1. PLACE OF DEATH COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Pennsylvania</u> b. COUNTY <u>Scranton</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scranton</u> d. STREET ADDRESS <u>415 Arthur Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Francis</u> Last <u>Gibbons</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 26, 1905</u> 9. AGE (In years) (If under 1 year, give birth date) <u>55</u> yrs. Months <u>5</u> Days <u>7</u> Hours <u>19</u> Min.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Accounting</u> 11. BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gibbons</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Anna McGuire</u> 16. SOCIAL SECURITY NO. <u>Unascertainable</u> 17. INFORMANT <u>The Medical Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Septicemia with hypotension</u> DUE TO (b) <u>Renal Failure</u> DUE TO (c) <u>Acute leukemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>6 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <u>August 3, 1961</u> to <u>August 7, 1961</u> , that (we) last saw the deceased alive on <u>August 7, 1961</u> , and that death occurred at <u>5:20 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Levin M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert H. Levin, M.D.</u>		22b. DATE SIGNED <u>8/7/61</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial - Trans it 8-8-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery Scranton, Penna.</u> 23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

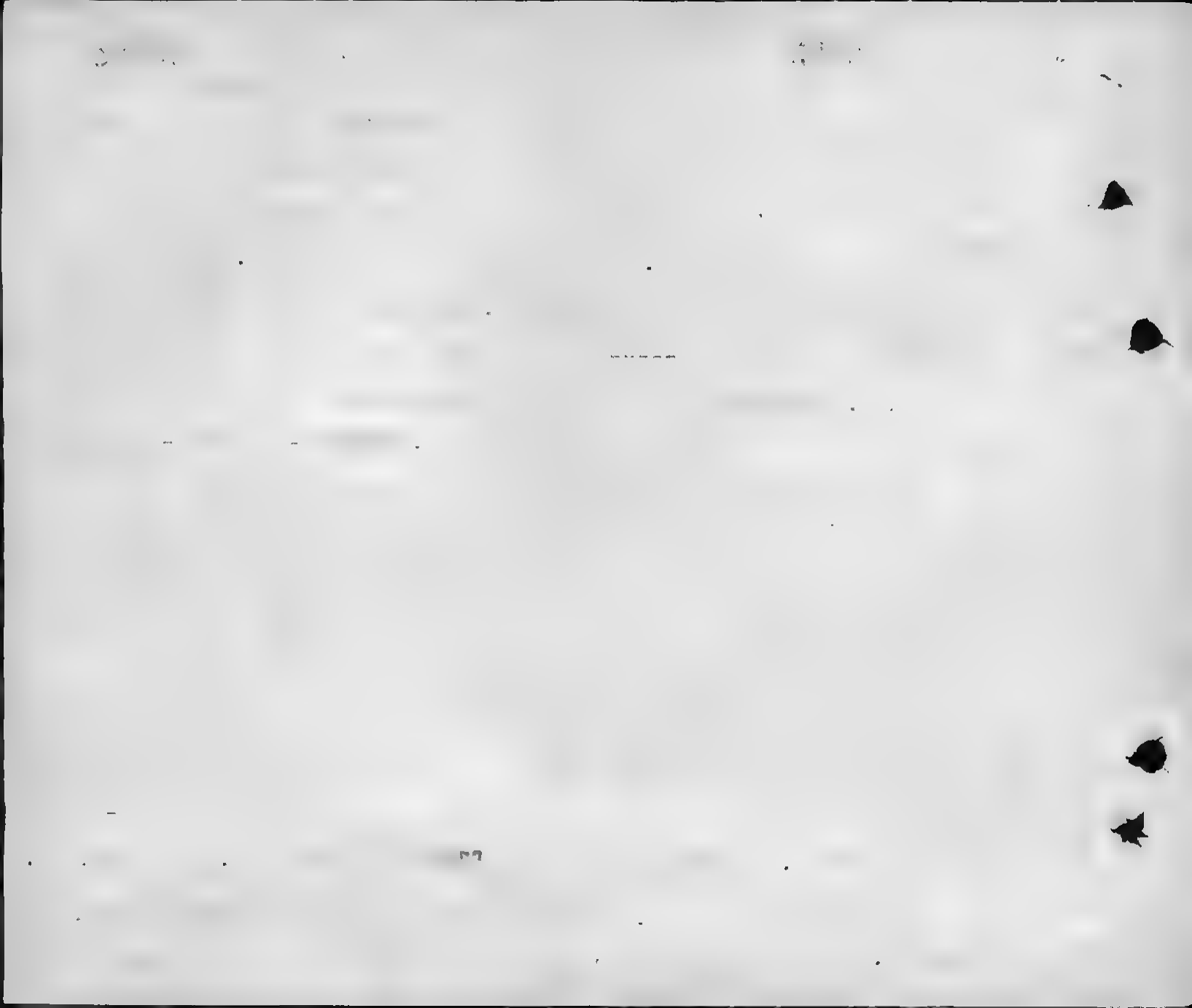
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9293

03284

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived; If institution; Residence before admission) b. STATE Maryland c. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8018 Glendale Rd.		d. STREET ADDRESS 8018 Glendale Road	
3. NAME OF DECEASED (Type or print) LORETTA S. GIBNEY		4. DATE OF DEATH Aug. 30, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 1888	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Mark L. Salamon	
14. MOTHER'S MAIDEN NAME Mary Leddy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Lorraine G. Swagart-daughter-same 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) INVALID & MULTIPLE SCLEROSIS 18 YRS		INTERVAL BETWEEN ONSET AND DEATH 10 MINUTE 10 YRS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this Hospital) attended the deceased from Aug 8, 1961 to Aug 30, 1961 that (I) (we) last saw the deceased alive on Aug 27, 1961 , and that death occurred at 6:55 AM from the causes and on the date stated above.			
22a. SIGNATURE Leo I. Donovan		22b. DATE 8-30-61	
22c. PHYSICIAN'S NAME (Type) LEO I. DONOVAN		22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/2/61	
23c. NAME OF CEMETERY OR CREMATORY St. Agnes Cemetery		23d. LOCATION (City, town or county) (State) West Chester, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR SEP 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur E. Kneass			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers P-1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3294

CERTIFICATE OF DEATH

09285

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 4 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY Binghamton c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 27 Leroy Street d. STREET ADDRESS 27 Leroy Street	
3. NAME OF DECEASED (Type or print) Leo Edward Gilroy		4. DATE OF DEATH Month August 10, Day 19 Year 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 8, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optician		9. AGE (In years IF UNDER 1 YEAR F UNDER 24 HRS last birthday) 50 yrs Months Days Hours M n.	
10b. KIND OF BUSINESS OR INDUSTRY Office		11. BIRTH PLACE (Country & State or foreign country) New York	
13. FATHER'S NAME Frank P. Gilroy		14. MOTHER'S MAIDEN NAME Eva P. Cole	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 070-03-5348	
18. CAUSE OF DEATH (Enter on only one cause per line, for (a), (b), and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure DUE TO Acquired Aortic Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland INTERVAL BETWEEN ONSET AND DEATH 2 hours 6 months	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 6, 1961, to August 10, 1961, that (I) (we) last saw the deceased alive on August 10, 1961, and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard P. Anderson</i>		22b. DATE SIGNED 8/11/61	
22c. PHYSICIAN'S NAME (Type) RICHARD P. ANDERSON, M.D.		22d. ADDRESS The Clinical Center National Institutes Of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 8-11-61		23b. DATE THEREOF 8-11-61	
23c. NAME OF CEMETERY OR CREMATORY Chenango Valley Cem.		23d. LOCATION (City, town or county) (State) Broome County, New York	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. RECEIVED BY REGISTRAR AUG 16 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

VR A15 (4)
15M 9/60

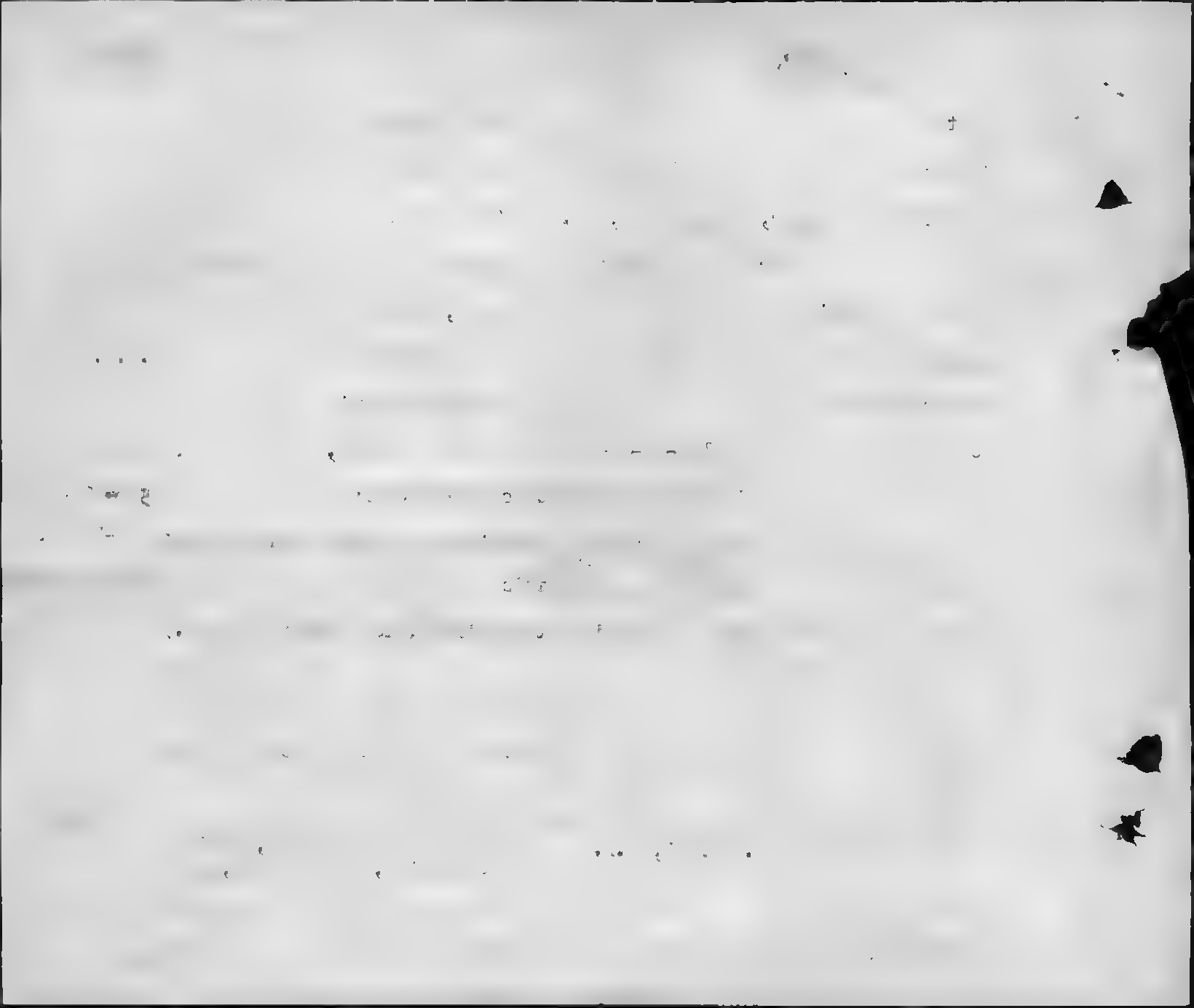
7 11.

8 12.



Order 8 June

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

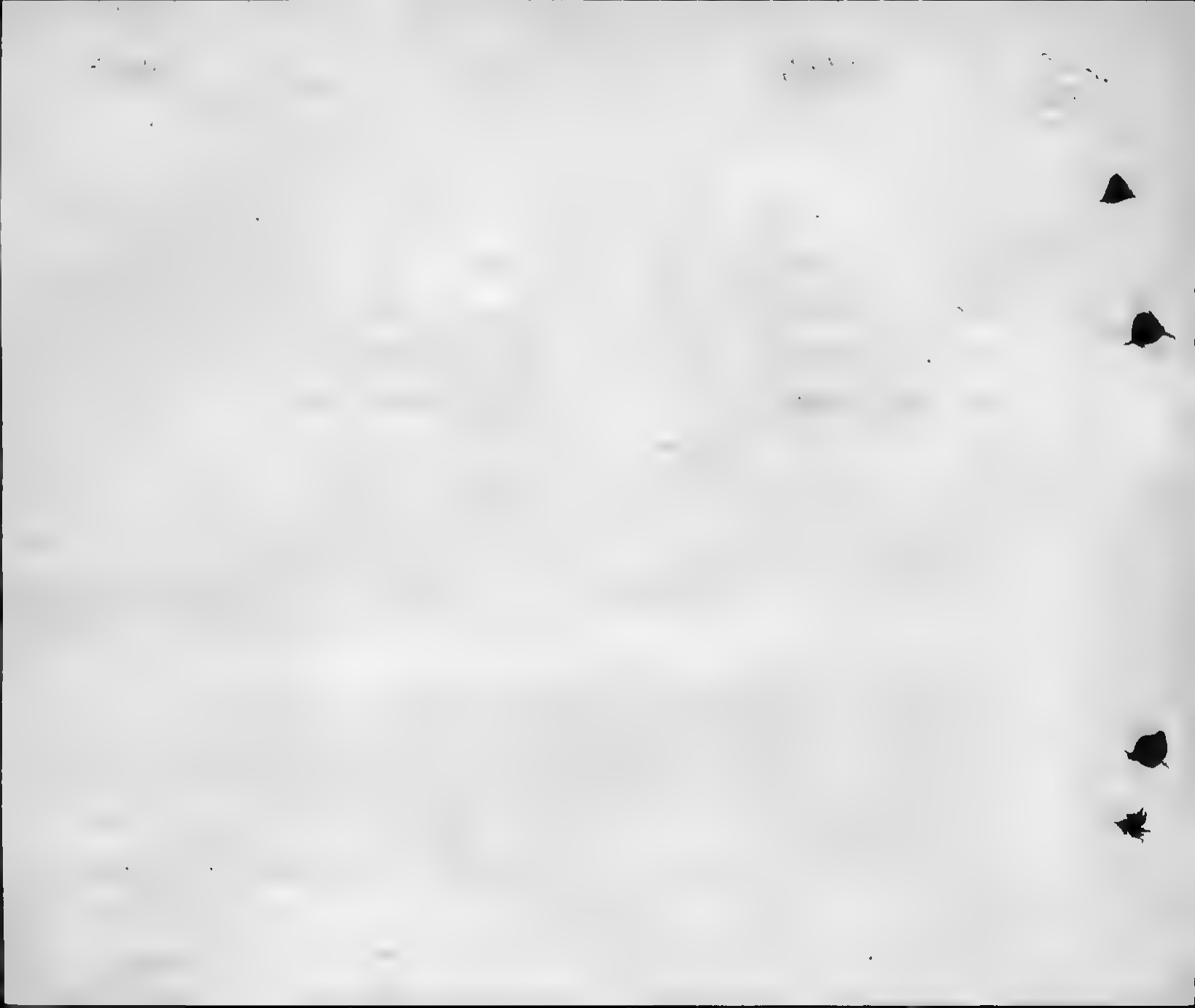
9296

09287

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in lb 21 hrs. 25 mins.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. STREET ADDRESS 8516-Irvington Ave.	
3. NAME OF DECEASED (Type or print) JOHN B GRIFFITH		4. DATE OF DEATH 8 27 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Admin. Assistant		10b. KIND OF BUSINESS OR INDUSTRY Red Cross	9. AGE (In years last birthday) 53
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Griffith		14. MOTHER'S MAIDEN NAME Laura Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Cleo Griffith-wife-same 2d		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) 163X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART IIe.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/15/61 to 8/27/61 , that (I) (we) last saw the deceased alive on 8/27/61 , and that death occurred at 8:27 P from the causes and on the date stated above.			
22a. SIGNATURE W. T. Joyce		22b. DATE SIGNED 8/28/61	
22c. PHYSICIAN'S NAME (Type) W. T. Joyce		22d. ADDRESS 8106 Maple Ridge Rd. Beth. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/30/61	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Krawe		DATE AUG 30 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

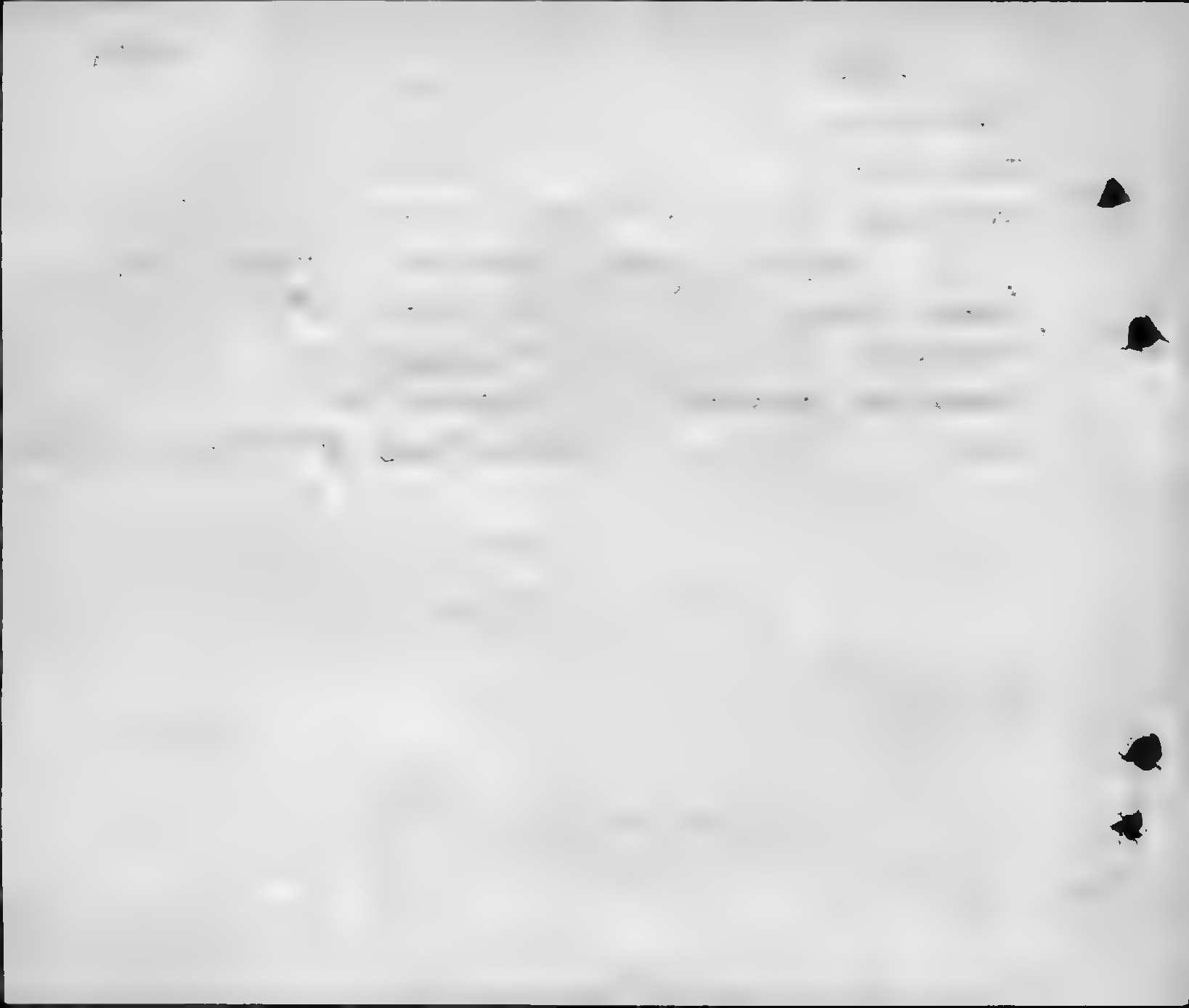


1
FOR STATE
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained or your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09288

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>216 Wayne Place, S.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia Lee Hartford</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>June</u> Day <u>15</u> Year <u>1943</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Leroy Hartford</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Trail</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of discharge or service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Shirley Fookes</u>		Address <u>3872-Gth St., S.E., Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC TAMPONADE</u> DUE TO (b) <u>TRAUMATIC LACERATION, RIGHT AND LEFT CARDIAC AURICULAR APPENDAGE</u> DUE TO (c) <u>AUTO ACCIDENT</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>INTERVAL BETWEEN ONSET AND DEATH SUDDEN</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto while riding in rear of motor cycle</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 - 8-20-1961</u> Hour a.m. <u>2:30</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City & town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/26/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>		22d. LOCATION (City, town, or country) <u>Colmar Manor Md</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>		ADDRESS <u>517-119th SE. WASH DC</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9298

CERTIFICATE OF DEATH

09289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY (In days) <u>15</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DEFC</u> b. COUNTY <u>DEFC</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>6918 WILLOW STREET NW</u>			
3. NAME OF DECEASED (Type or print) <u>Frank Augustus Harrison</u>				4. DATE OF DEATH Day <u>8</u> Month <u>12</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4-15-1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.				10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired W & J Sloan</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE STORE</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Not known</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Alice Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-03-0935</u>			
17. INFORMANT <u>JOSEPH A. HILLEBERT, 7510 CARROLL AVE., TAKOMA PARK, MD.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastric Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of Stomach (cardia)</u> (c) <u>15</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> <u>6 mo 2</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 11</u> 19<u>61</u> to <u>Aug 12</u> 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>Aug 11</u> 19<u>61</u>, and that death occurred at <u>7:15</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James H. Walters M.D.</u>				22b. DATE SIGNED <u>8-12-61</u>		22c. PHYSICIAN'S NAME (Type) <u>James H. Walters</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Harris</u>				25a. REC'D BY REGISTRAR <u>AUG 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

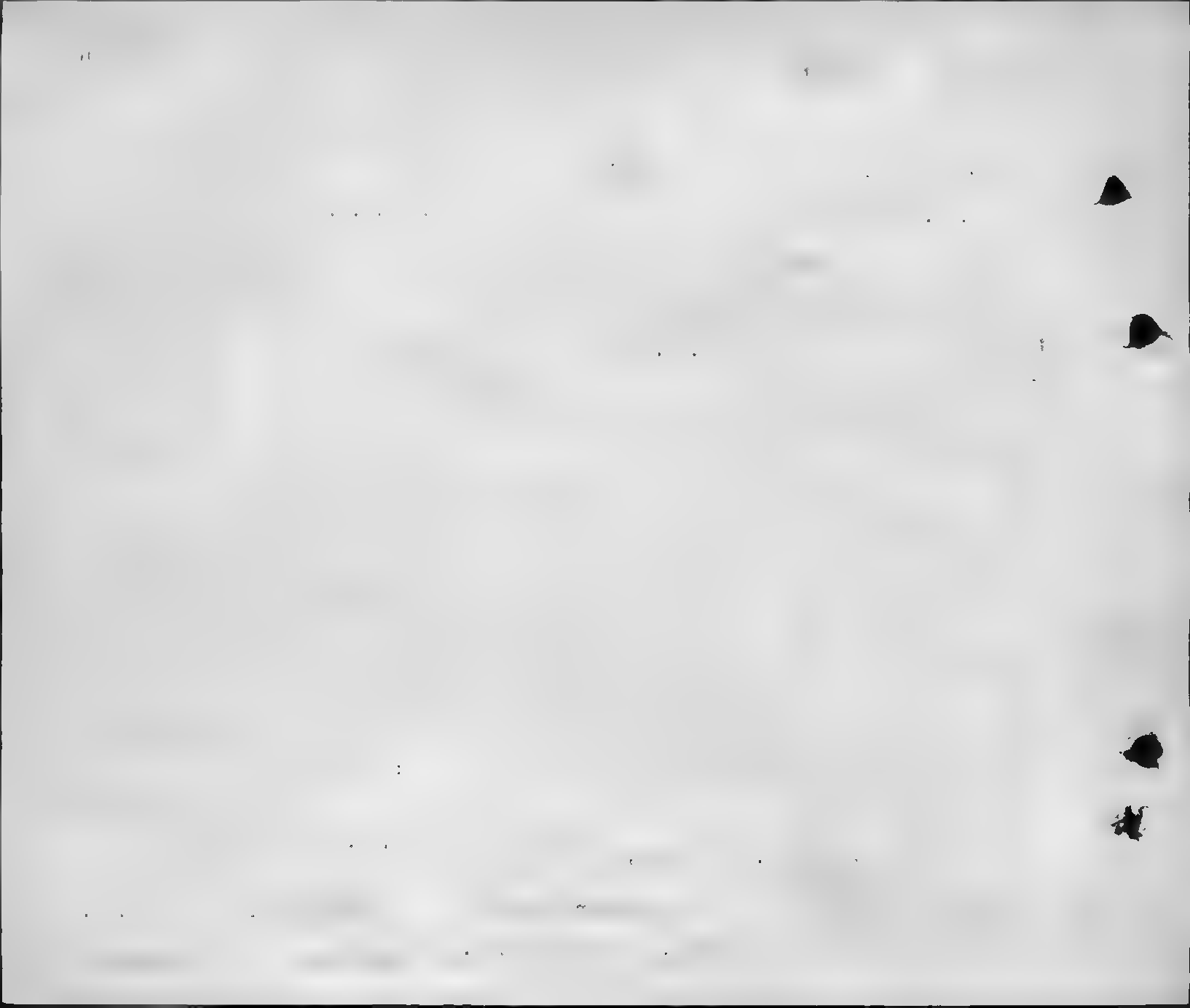
CERTIFICATE OF DEATH

9299

03290

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1823 P. St. N.W.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Aubrey Elbert Haynes		4. DATE OF DEATH Month Day Year August 21 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-2-95	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Lindsey Haynes		14. MOTHER'S MAIDEN NAME Molly Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 263 16 2248	
17. INFORMANT (W) Elizabeth M. Haynes, Same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac-respiratory cessation (b) Congestive heart failure (c) Rheumatic mitral stenosis and insuff.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Latent cirrhosis & asistia			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from August 7, 1961, to August 21, 1961, that (we) last saw the deceased alive on August 21, 1961, and that death occurred at 1:10 PM from the causes and on the date stated above.			
22a. SIGNATURE Joseph H. Eusterman M.D.			
22b. DATE 21 August 1961			
22c. PHYSICIAN'S NAME (Type) JOSEPH H. EUSTERMAN, LT MC USN			
22d. ADDRESS NNMC Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass. Washington, D. C.			
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE AUG 24 '61			

TO HOSPITAL OR A PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be filed with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9300

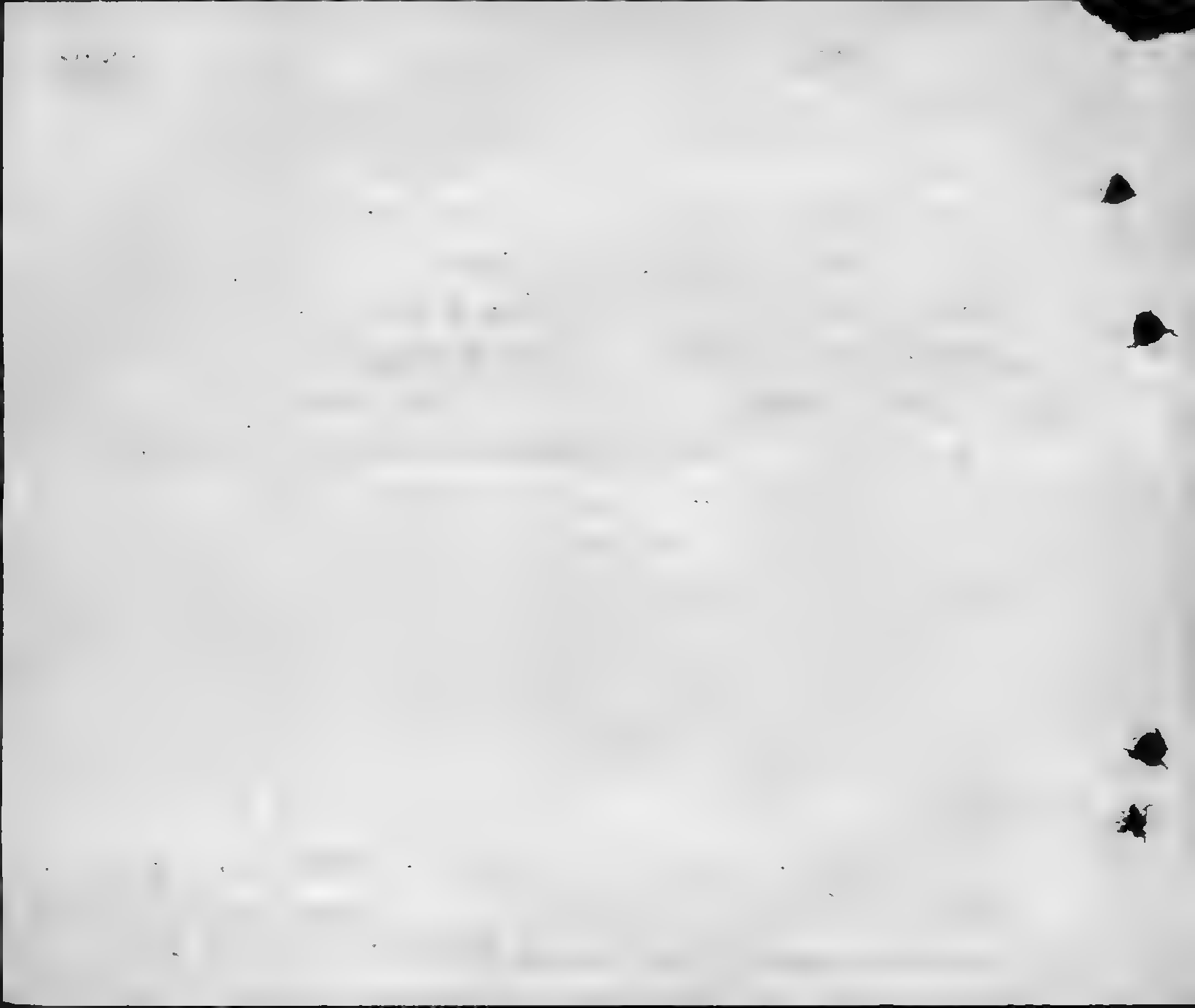
CERTIFICATE OF DEATH

09291

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>344 Howard Avenue</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>344 Howard Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>344 Howard Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Edwin D. Henley</u>		4. DATE OF DEATH <u>Aug. 17, 1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 19, 1892</u>		9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) <u>68</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Supt. Public Works</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Town of Rockville</u>				11. BIRTHPLACE (County & State or foreign country) <u>Montgomery Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Henley</u>				14. MOTHER'S M maiden NAME <u>Ohler Reddicord</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-18-7218</u>				17. INFORMANT <u>Beatrice L. Henley</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIPYRIMETHYL METHANESULFONATE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1957</u> to <u>August 18, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 15, 1961</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above.				22a. SIGNATURE <u>Gordon S. Rosenberger</u>				22b. DATE SIGNED <u>Aug. 24, 1961</u>			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/19/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>			
23d. LOCATION (City, town or county) (State) <u>Gaithersburg, Montgomery Co. Md.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Tejon Wheeler Funeral Home</u>				25a. RECEIVED BY REGISTRAR <u>Aug 21 61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>				25c. ADDRESS <u>1331 - E. Montg. Ave. Rockville, Md.</u>				25d. DATE <u>Aug 21 61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 2 of 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9307

CERTIFICATE OF DEATH

09292

PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>13407 Sherwood Forest Dr</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>13407 Sherwood Forest Dr</u>									
3. NAME OF DECEASED (Type or print) <u>Boyd L. HENRY</u>		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1961</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 31, 1889</u>									
9. AGE (In years last birthday) <u>71</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
11. BIRTHPLACE (County & State, or foreign country) <u>Martinsburg W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>DANIEL L. HENRY</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>NO</u>											
16. SOCIAL SECURITY NO. <u>NO</u>											
17. INFORMANT Address <u>Mrs. Margorie Hall 13407 Sherwood Forest Dr.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> DUPLICATE <u>ARTERIO SCLEROSIS</u> </td> <td style="width: 40%;"> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>10 YRS</u> </td> </tr> </table>				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> DUPLICATE <u>ARTERIO SCLEROSIS</u>	INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>10 YRS</u>						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> DUPLICATE <u>ARTERIO SCLEROSIS</u>	INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>10 YRS</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRO VASCULAR ACCIDENT</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <table border="1" style="width: 100%;"> <tr> <td style="width: 25%;"> 20c. TIME OF INJURY Month, Day, Year <u>8-16-61</u> Hour a.m. <u>19</u> p.m. </td> <td style="width: 25%;"> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> </td> <td style="width: 25%;"> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) </td> <td style="width: 25%;"> 20f. (City or town) (County) (State) </td> </tr> </table>				20c. TIME OF INJURY Month, Day, Year <u>8-16-61</u> Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
20c. TIME OF INJURY Month, Day, Year <u>8-16-61</u> Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> , 19 <u>61</u> to <u>8/16</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>8/6</u> , 19 <u>61</u> , and that death occurred at <u>3:35 AM</u> , from the causes and on the date stated above. <table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"> 22a. SIGNATURE <u>Henry Stout M.D.</u> </td> <td style="width: 50%;"> 22b. DATE SIGNED <u>8/16/61</u> </td> </tr> <tr> <td> 22c. PHYSICIAN'S NAME (Type) <u>H.W. STOUT</u> </td> <td> 22d. ADDRESS <u>10011 GEORGIA AVE SILVER SPRING MD</u> </td> </tr> </table>				22a. SIGNATURE <u>Henry Stout M.D.</u>	22b. DATE SIGNED <u>8/16/61</u>	22c. PHYSICIAN'S NAME (Type) <u>H.W. STOUT</u>	22d. ADDRESS <u>10011 GEORGIA AVE SILVER SPRING MD</u>				
22a. SIGNATURE <u>Henry Stout M.D.</u>	22b. DATE SIGNED <u>8/16/61</u>										
22c. PHYSICIAN'S NAME (Type) <u>H.W. STOUT</u>	22d. ADDRESS <u>10011 GEORGIA AVE SILVER SPRING MD</u>										
23a. BURIAL, CREMATION, REMAINS (Specify) <u>8-19-61</u>											
23b. DATE THEREOF <u>8-19-61</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>											
23d. LOCATION (City, town or county) (State) <u>Switzland - Md</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>											
25a. REC'D BY REGISTRAR <u>300 4th St NE Wash DC</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate must be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 ~~13~~
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9302
CERTIFICATE OF DEATH
09293

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 708 Philadelphia Avenue Cur-Lu Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before adm. shown) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8106 Tahona Drive	
3. NAME OF DECEASED (Type or print) HERMAN L. HERMANSON		4. DATE OF DEATH Month Aug Day 1 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Able, Finland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman L. Hermanson		14. MOTHER'S MAIDEN NAME Katherine----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-09-1663	
17. INFORMANT Mrs. Lillian C. Donaldson same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332X DUE TO Cerebral thrombosis & M. Hemiplegia Generalized arteriosclerosis Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Chronic pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 3 days several years " "	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 18, 1958 to Aug 1, 1961 , that (I) was last saw the deceased alive on Aug 1, 1961 , and that death occurred 12:00 PM from the causes and on the date stated above.			
22a. SIGNATURE IRWIN I. YAGER M.D.		22b. DATE SIGNED Aug 1, 1961	
22c. PHYSICIAN'S NAME (Type) IRWIN I. YAGER M.D.		22d. ADDRESS 3055-16th St. N.W., WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8/4/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		25. REC'D BY REGISTRAR AUG 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9303
CERTIFICATE OF DEATH

09294

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5818 Sherrier Place	
3. NAME OF DECEASED (Type or print) Bertha Virginia Hiley		4. DATE OF DEATH Month August Day 4 Year 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 1, 1912	
9. AGE (In years last birthday) 48 yrs.		10. F UNDER 1 YEAR Months 4 Days 4 Hours 48 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (Country & State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Albert Robertson		14. MOTHER'S MAIDEN NAME Clara Sheets	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMATION The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acidosis 4 33.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Prolonged anoxia and temporary cardiac arrest DUE TO (c) Myasthenia gravis	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 24 hours	
21. I certify that (I) (this hospital) attended the deceased from August 3, 1961 to August 4, 1961 that (I) (we) last saw the deceased alive on August 4, 1961 , and that death occurred at 7:32 PM from the causes and on the date stated above.		22a. SIGNATURE Edward L. Eyerman 22b. DATE 8/5/61	
22c. PHYSICIAN'S NAME (Type) EDWARD L. EYERMAN, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/1961	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Bladensburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawlinski		25a. REC'D BY REGISTRAR DATE AUG 8 '61	
25b. REGISTRAR'S SIGNATURE William S. Kraus			

18. 11. 1941

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9304

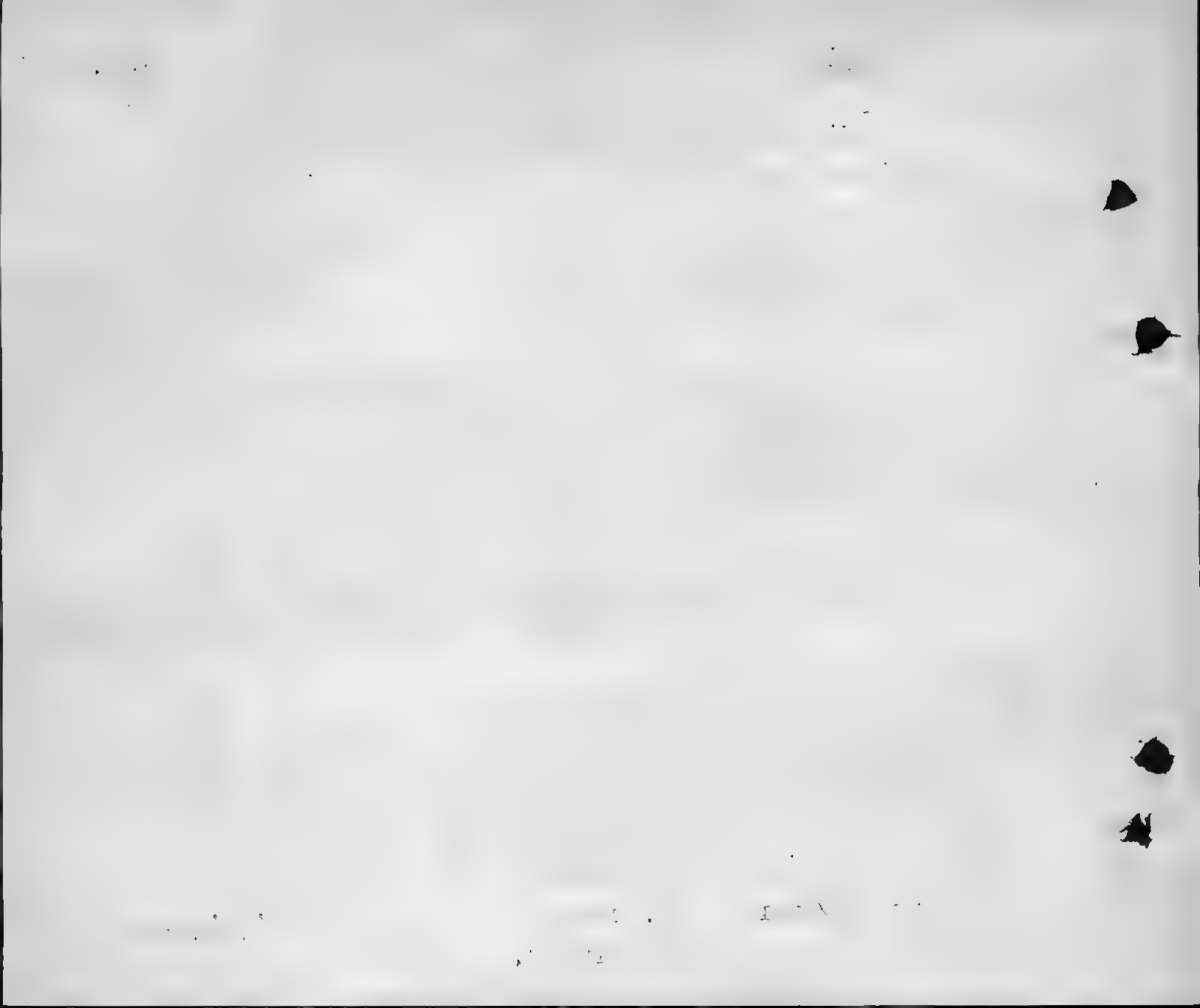
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19295

1
FOR STATE
HEALTH DEPT.
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY in 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R-609 Norwood Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>R 609 Norwood Rd</u>							
3. NAME OF DECEASED (Type or print) <u>Elgar Lenwood Holland</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1961</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-16-1918</u>		9. AGE (In years, last birthday) <u>42</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months Days	Hours Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>				10b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>							
13. FATHER'S NAME <u>Clarence Holland</u>				14. MOTHER'S MAIDEN NAME <u>Martha Nickens</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>Rockville, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> DUE TO <u>Found dead in auto</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Found dead in auto</u> DUE TO <u>Found dead in auto</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hose attached to exhaust returning into car</u> 20c. TIME OF INJURY Month, Day, Year <u>8-10-61</u> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> Hour a.m. <u>7</u> p.m. <u>8:00</u> 20f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>md</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u> DATE SIGNED <u>8-13-61</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8/15/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u> 23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>											



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M
070
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9305

Item 14 Film 8/26/61 iwk

08296

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MONTGOMERY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>	
d. NAME OF HOSPITAL (If in hospital, give street address) <i>De Dear Gardens Nursing Home</i>		d. STREET ADDRESS <i>19215 WENDELL STREET</i>	
3. NAME OF DECEASED (Type or print) <i>MARIAN W. HOUCK</i>		4. DATE OF DEATH <i>Aug 21 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB. 11, 1884</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Portsmouth, New Hamp.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frank W. Hogan</i>		14. MOTHER'S MAIDEN NAME <i>Helen unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Wm L. Houck, Jr. (same as #2)</i>	
17. INFORMANT <i>Wm L. Houck, Jr. (same as #2)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		<i>30 min.</i>	
(b) <i>Senile Arteriosclerosis</i>		<i>10 years</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 1958</i> to <i>21 Aug 1961</i> , that (I) (we) last saw the deceased alive on <i>1 Aug 1961</i> , and that death occurred at <i>4:15 P.</i> M., from the causes and on the date stated above			
22a. SIGNATURE <i>H. B. Queen M.D.</i> M.D.		22b. DATE SIGNED <i>21 Aug 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. B. QUEEN M.D.</i>		22d. ADDRESS <i>7112 Willow Ave TAKOMA PARK, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 24, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>Arthur L. Hanna</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>AUG 24 '61</i>	

(over)

8/22/61

Mr. Frank J. Broschart, Dep. Med. Examiner notified and
authorized Mr. G. B. Queen to sign certificate

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

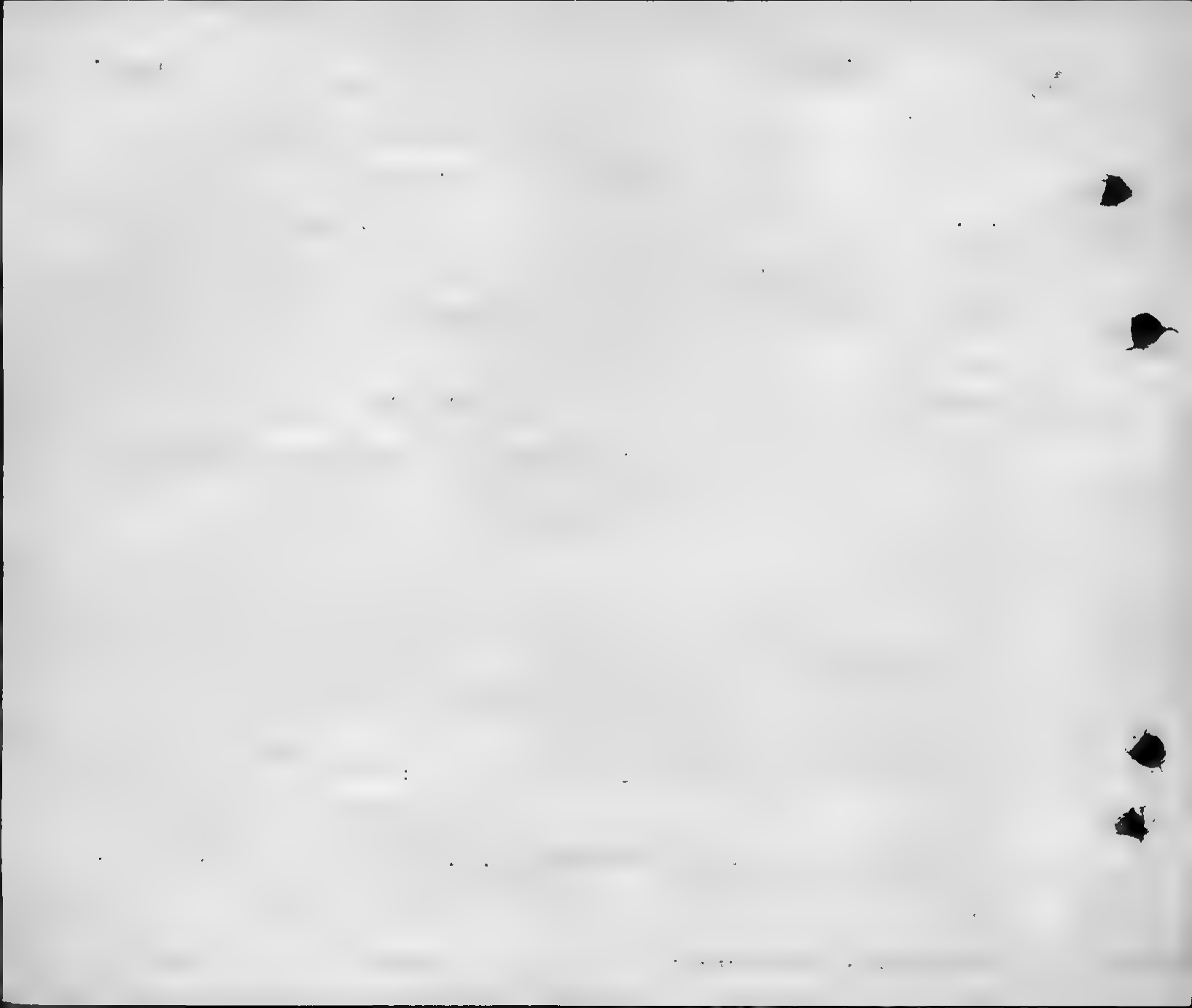
VR A15 (4)
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9306 CERTIFICATE OF DEATH 09297											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Triangle					
c. LENGTH OF STAY IN 1b 10 days						d. STREET ADDRESS 36 A Purvis Drive					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Judy Lee James						4. DATE OF DEATH August 10 1961					
5. SEX Female						6. COLOR OR RACE Caucasian					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 12-4-40					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						9. AGE (In years last birthday) 20 yrs.					
10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country) Kansas					
13. FATHER'S NAME Ernest Hymer						14. MOTHER'S MAIDEN NAME Margaret Braun					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 514-40-1063					
17. INFORMANT (H) Jack "J" James same as #2 above						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 34.3 DUE TO Lymphoblastic leukemia, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from July 31, 1961 to August 10, 1961, that (if) (we) last saw the deceased alive on August 10, 1961, and that death occurred at 8:00 AM, from the causes and on the date stated above.											
22a. SIGNATURE Lewis Ned Cahill						22b. DATE SIGNED August 10, 1961					
22c. PHYSICIAN'S NAME (Type) Lewis Ned Cahill, LCDR MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial-Shipment August 10, 1961						23c. NAME OF CEMETERY OR CREMATORY Municipal Cemetery					
23d. LOCATION (City, town or county) Bonner Springs						23e. (State) Kansas					
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler, Rockville, Md.						25a. REC'D BY REGISTRAR AUG 11 '61					
25b. REGISTRAR'S SIGNATURE Curtis S. Evans											

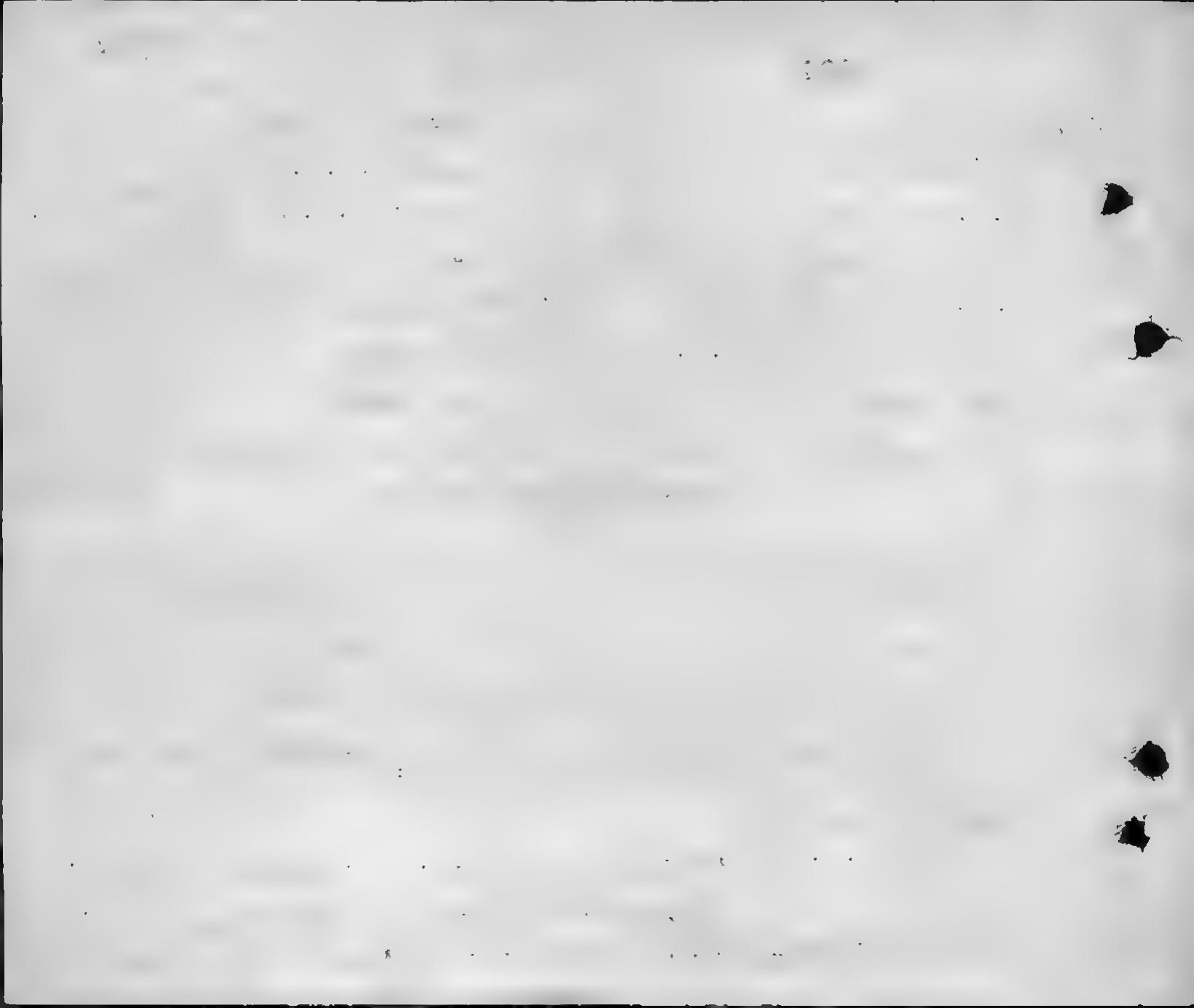


TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9307											
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 24 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia				b. COUNTY District of Columbia				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. STREET ADDRESS 1561 33rd St. N.W.				e. DATE OF DEATH August 16 1961				f. DATE OF DEATH August 16 1961			
3. NAME OF DECEASED (Type or print) Howard Lobdell Jennings				5. SEX Male				6. COLOR OR RACE Caucasian			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH September 26, 1900				9. AGE (In years last birthday) 60 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (County & State or foreign country) Massachusetts			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Ralph Jennings				14. MOTHER'S MAIDEN NAME Belle Hutchin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 577 26 6210				17. INFORMANT Gloria Jennings Same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 168X DUE TO Adenocarcinoma, Right Lung Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH one month				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
22f. City or town (County) (State)				22g. City or town (County) (State)				22h. City or town (County) (State)			
21. I certify that (this hospital) attended the deceased from July 23, 1961 to August 16, 1961, that (we) last saw the deceased alive on August 16, 1961, and that death occurred at 2:25 PM from the causes and on the date stated above.											
22a. SIGNATURE D. L. KELLEY				22b. DATE August 16, 1961				22c. PHYSICIAN'S NAME (Type) D. L. KELLEY, LT MC USN			
22d. PHYSICIAN'S NAME (Type) D. L. KELLEY, LT MC USN				22e. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22f. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF August 21 1961				23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town or county) Arlington				23e. LOCATION (City, town or county) Arlington				23f. LOCATION (City, town or county) Va.			
24. FUNERAL DIRECTOR'S SIGNATURE DeVol 2224 Wisconsin Ave. N.W. Washington, D. C.				25a. REC'D BY REGISTRAR DATE AUG 21 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
9/60

1
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9308
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY (If not in hospital, give street address) <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>810 Johnson Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Emma Jennings</u>	4. DATE OF DEATH <u>August 10 1961</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>June 28, 1899</u>	9. AGE (In years last birthday) <u>62</u> Yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Telephone Operator</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Levi C. Gill</u>	
14. MOTHER'S MAIDEN NAME <u>Augusta E. Wilson</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		
16. SOCIAL SECURITY NO. <u>Washington Sanitarium and Hospital</u>		17. INFORMANT <u>32X</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute Passive Congestion - Cardiac</u> (c) <u>Hypertensive Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I):		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1960</u> to <u>Aug. 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 9, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Hare</u>		22b. DATE SIGNED <u>Aug 10, 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>		22d. ADDRESS <u>7600 Carroll Ave., T.P. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince George's Co., Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR <u>AUG 16 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

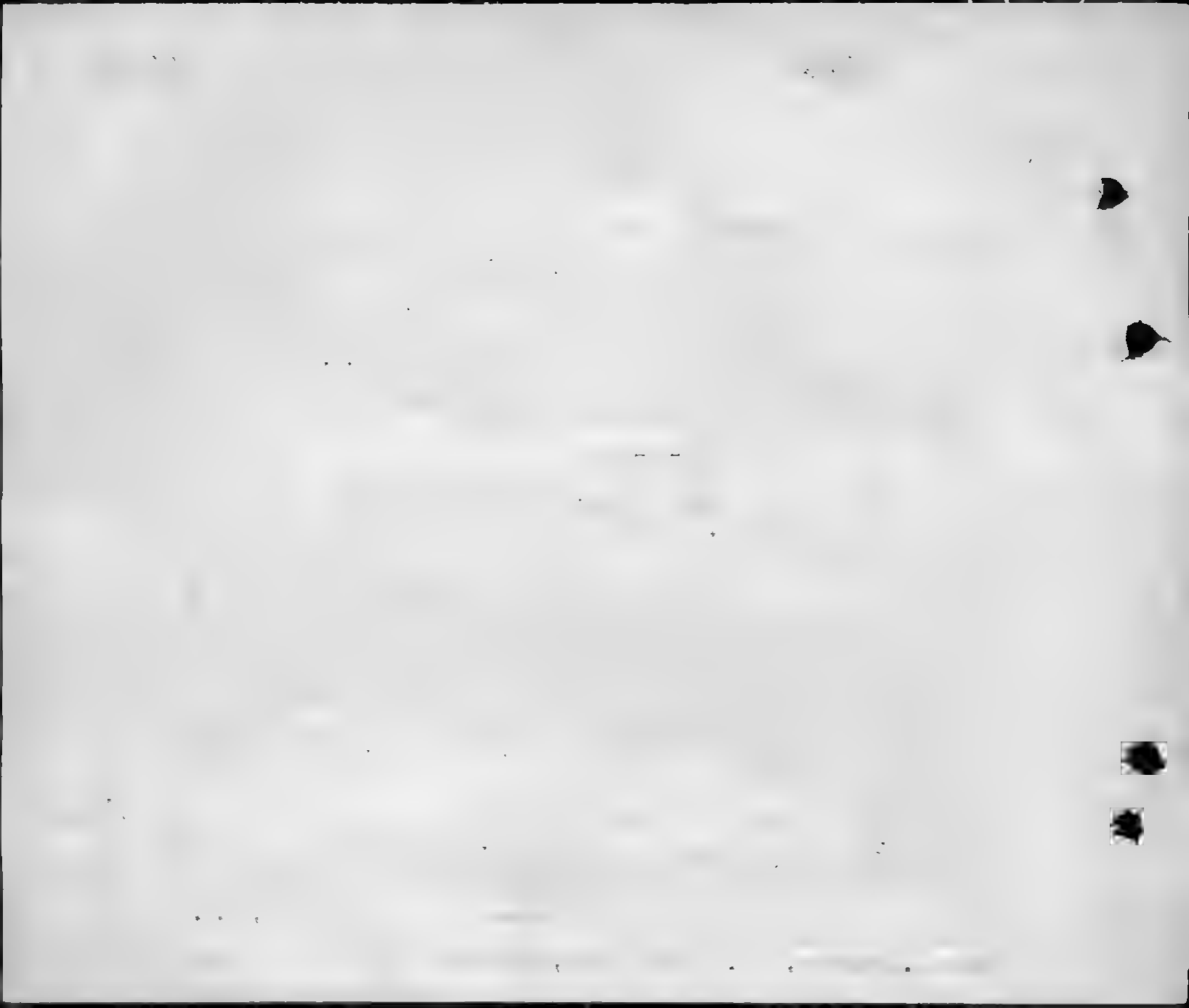


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
9309		CERTIFICATE OF DEATH	
09300			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY (If not in hospital, give street address) <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> d. STREET ADDRESS <u>419 Constitution Ave. N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Ira Ellsworth Johnson</u>		4. DATE OF DEATH <u>August 22, 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>8-27-02</u>	
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albanus Stevenson Tudor Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Edith Yoder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>216-09-9263</u>	
17. INFORMANT <u>Scn-in-law</u>		Address <u>13914 Parkland Dr. Rockville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>due to</u> (c) <u>Ecologan Disease.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ecologan Disease.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> to <u>8/22</u> , 1961, that (I) (we) last saw the deceased alive on <u>8/22</u> , 1961, and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W.B. Wardrop MD</u>		22b. DATE SIGNED <u>8/23/61</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>W.B. WARDROP, MD</u>		22d. ADDRESS <u>800 Pershing Drive, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Zisk</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		DATE <u>AUG 26 '61</u>	



TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 2 is to be filed with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

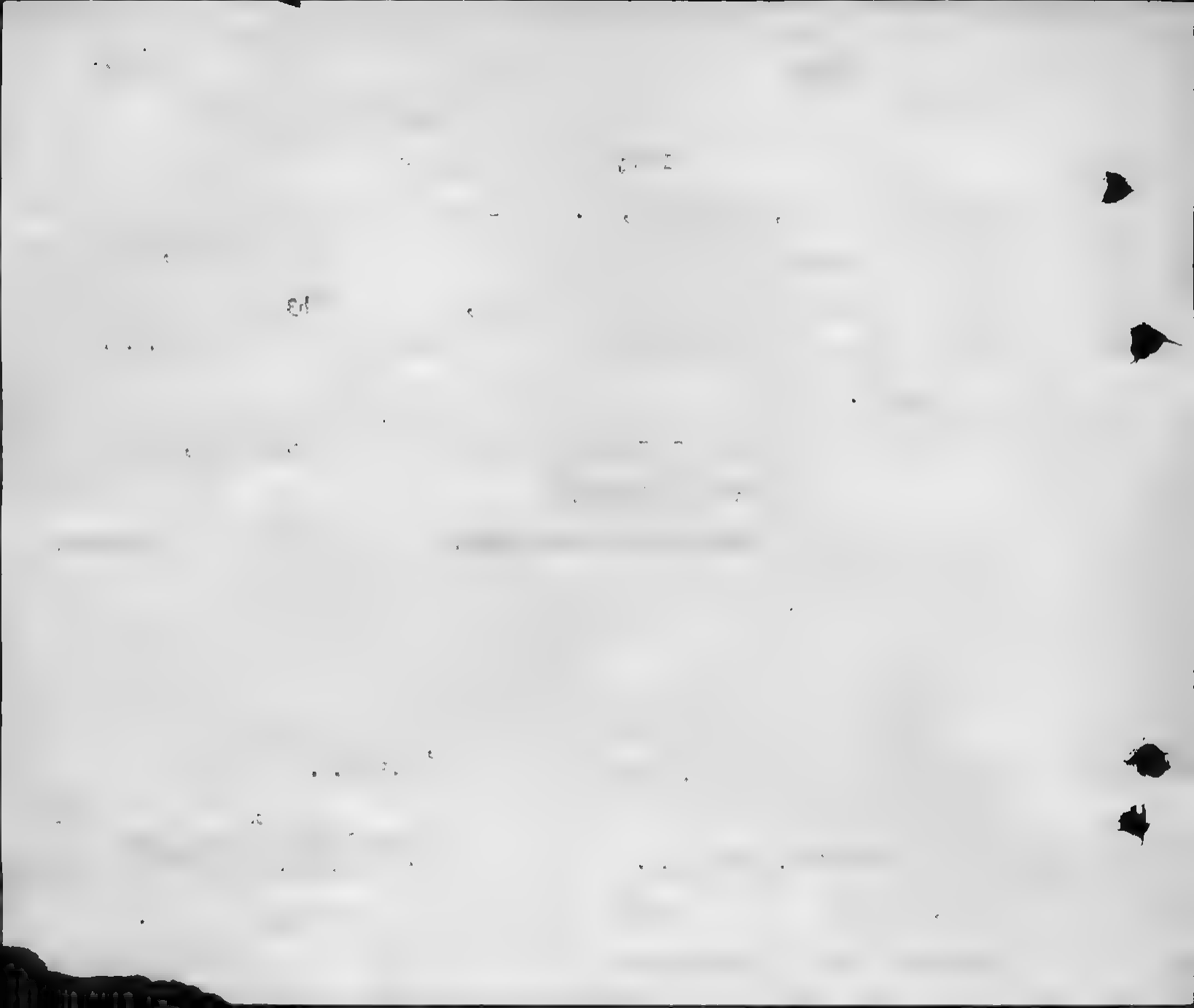
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9310

09301

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>14-A West Del Ray Avenue</u> d. STREET ADDRESS <u>14-A West Del Ray Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Jewell Gwendolyn Johnson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> , Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 28, 1918</u>	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. (In days) Months Days Hours Min. <u>43</u> s)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTH PLACE (County & State or foreign country) <u>North Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur J. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Georgia Nelson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>468-12-4502</u>	
17. INFORMANT <u>The Medical Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hematoma</u> DUE TO <u>204.3</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute Myelogenous Leukemia</u> (c) <u>10 Months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 Months</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. City or town (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>August 21, 1961</u> , to <u>August 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 21, 1961</u> , and that death occurred at <u>4:32 P.M.</u> on the causes and on the date stated above.	
22a. SIGNATURE <u>Robert H. Levin</u>		22b. DATE SIGNED <u>8/22/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT H. LEVIN, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/23/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>AUG 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

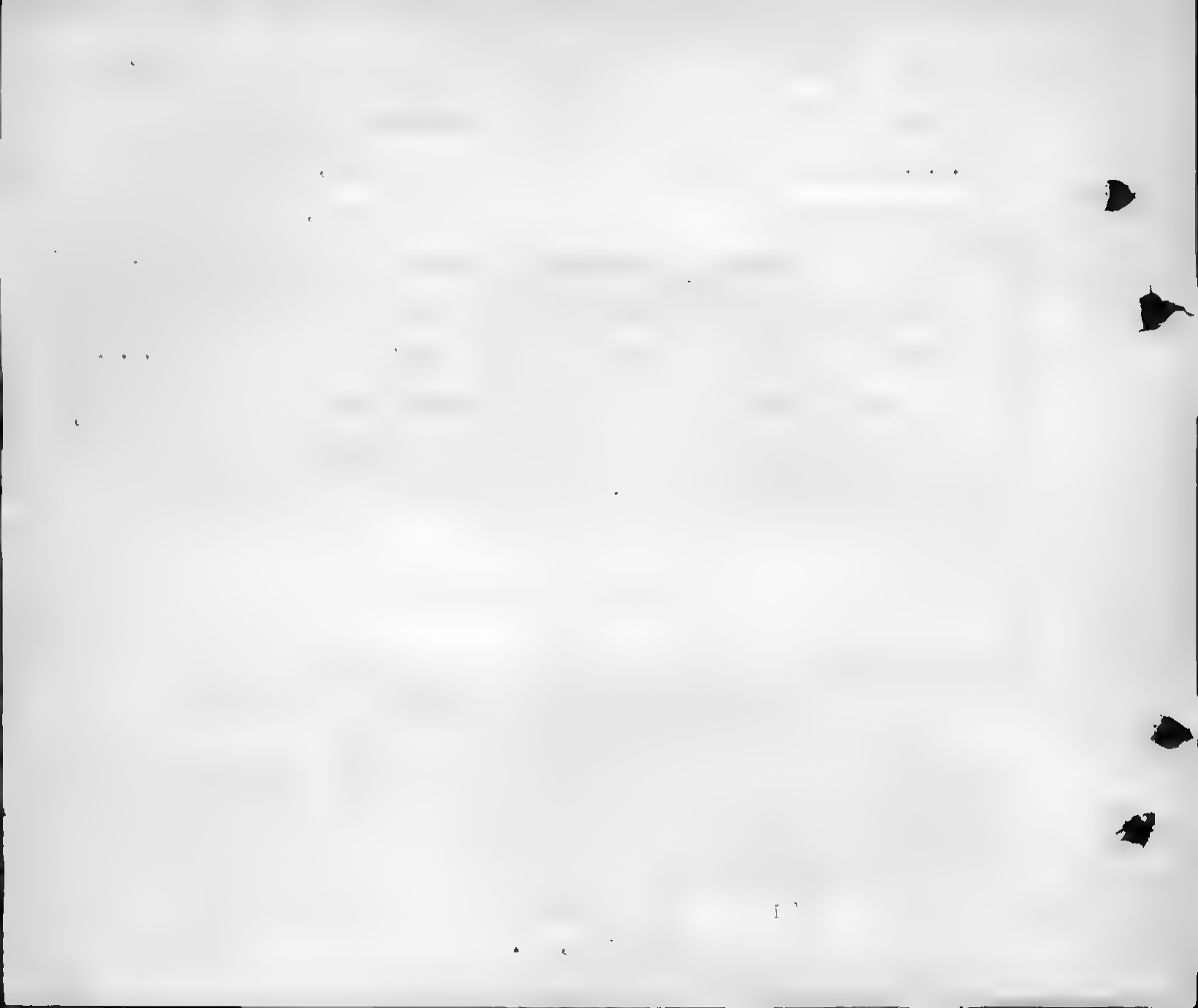


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9311
CERTIFICATE OF DEATH
09302

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. #1 Gaithersburg, Md				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Annons Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md			
f. STREET ADDRESS 211 Spring Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Garfield Last Johnson				4. DATE OF DEATH Month August Day 12 Year 1961			
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/1903	
9. AGE (In years lost birthday) 57 yrs		F UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.		IF UNDER 24 HRS Months 57 Days 57 Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Johnson				14. MOTHER'S MAIDEN NAME Georgia Hayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Mrs Kathleen Offutt (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure DUE TO C.V.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertension DUE TO Hypertension (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/15 , 19 61 , to 8/12 , 19 61 , that (I) (we) last saw the deceased alive on 8/11 , 19 61 , and that death occurred at 3:45 A. M., from the causes and on the date stated above.							
22a. SIGNATURE Lucius L. Leal				22b. DATE SIGNED 8/11/61			
22c. PHYSICIAN'S NAME (Type) Lucius L. Leal				22d. ADDRESS Gaithersburg, Md			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/18/61		23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cem		23d. LOCATION (City, town or county) (State) Clarksburg, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				25a. REC'D BY REG STRAR DATE AUG 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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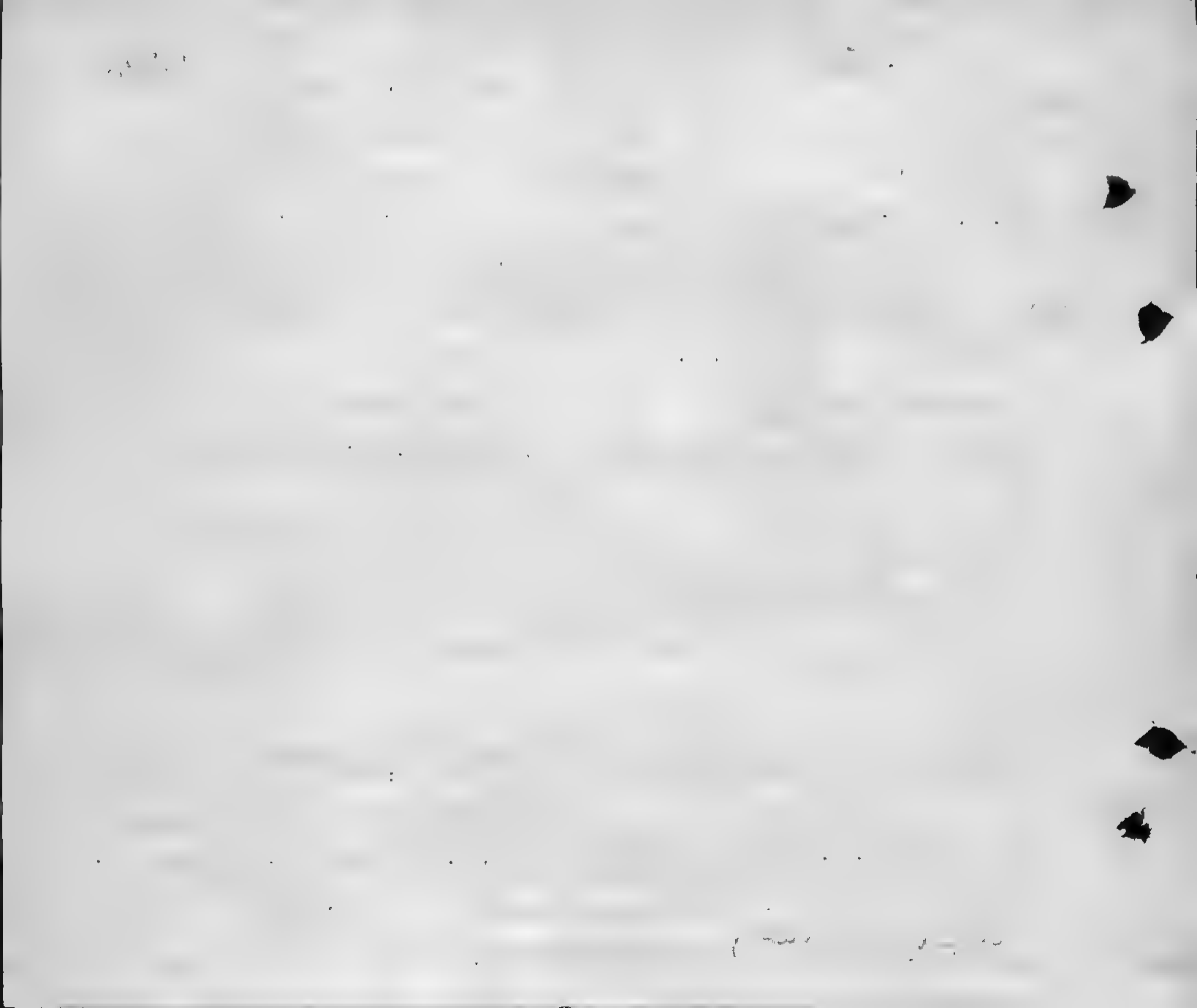
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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9312					09303				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Montgomery					a. STATE Pennsylvania				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Masontown				
c. LENGTH OF STAY IN 1b 6 days					d. STREET ADDRESS 539 N. Main St.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital					b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last Albert Jack Kermes					Month Day Year August 9 19 61				
5. SEX Male					6. COLOR OR RACE Caucasian				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 11-16-28				
9. AGE (In years last birthday) 32 yrs.					10. AGE (In years last birthday) 32 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer					11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				
10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Albert John Kermes					14. MOTHER'S MAIDEN NAME Rose Roth				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II					16. SOCIAL SECURITY NO. 163-22-5705				
17. INFORMANT (W) Marilyn G. Kermes					Address same as #2 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)					cardiac stenosis				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					due to Rheumatic heart disease				
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)					unintentional				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from August 3, 1961 to August 9, 1961 that (2) (we) last saw the deceased alive on August 9, 1961 , and that death occurred at 11:00 AM from the causes and on the date stated above.									
22a. SIGNATURE B. H. Rice					22b. DATE SIGNED August 10, 1961				
22c. PHYSICIAN'S NAME (Type) B. H. RICE, LT MC USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF August 14, 1961				
23c. NAME OF CEMETERY OR CREMATORY Arlington National					23d. LOCATION (City, town or county) (State) Arlington Va.				
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey					25. REC'D BY REGISTRAR AUG 14 '61				
ADDRESS 7550 Wisconsin Ave, Bethesda, Md.					25b. REGISTRAR'S SIGNATURE Arthur L. Pumphrey				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

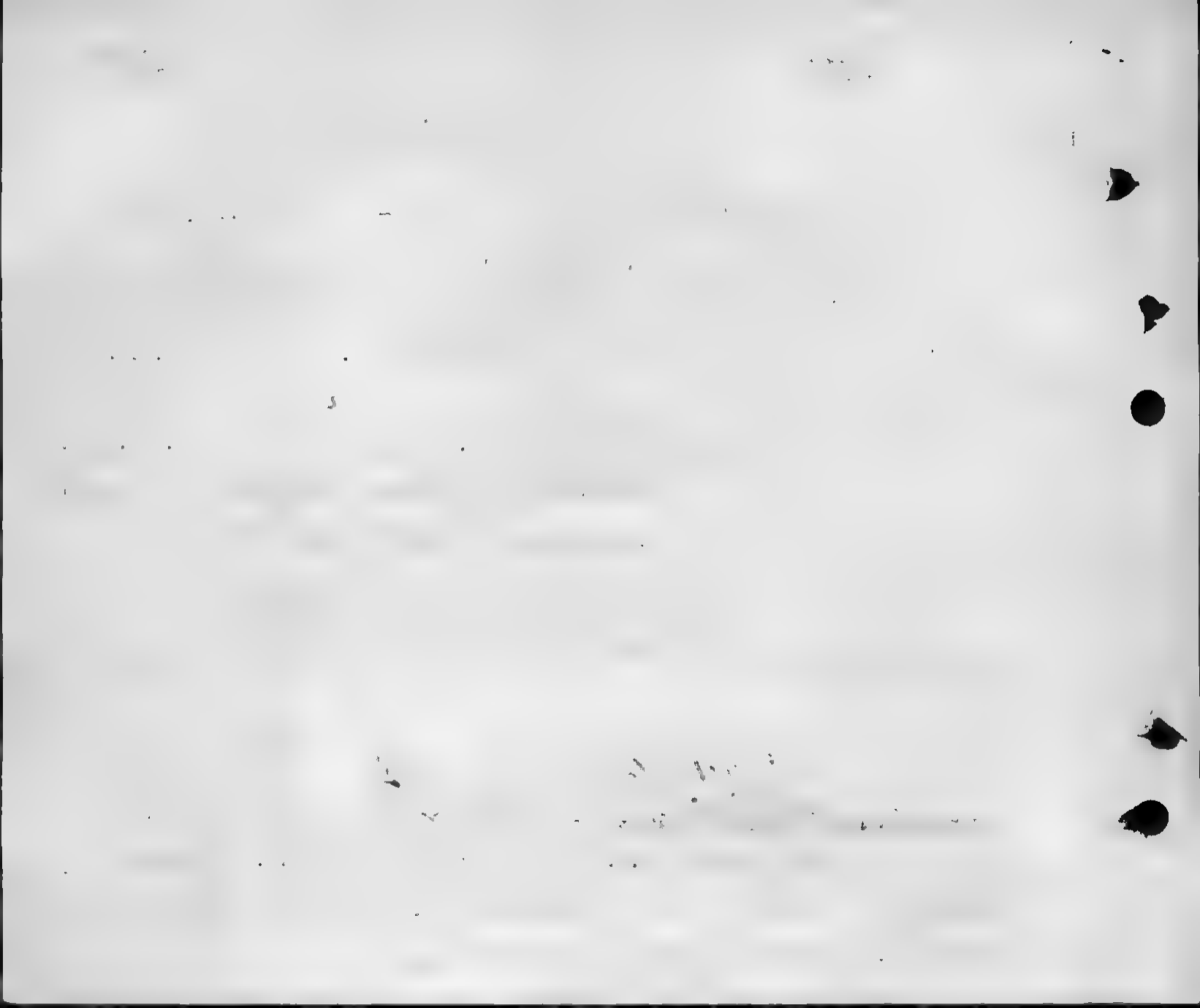
9313

09304

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY (in days) _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3335 - Military Rd., N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>F.</u> Last <u>Keyser</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/5/1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Sutton, N. Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Keyser</u>		14. MOTHER'S MAIDEN NAME <u>Grace Shattuck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-12-7827</u>	
17. INFORMANT Address <u>Charles H. Omo 5514 Cedar Pkwy. Ch. Ch., Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis</u> (c), stating the underlying cause last. <u>34da</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-23</u> <u>1961</u> to <u>8-24</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>8-24</u> <u>1961</u> and that death occurred at <u>9A</u> from the causes and on the date stated above.			
22. SIGNATURE <u>Jonathan Williams</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Jonathan Williams, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1726 "M" Street, N.W. Washington D. C.</u>	
22e. DATE SIGNED <u>8/24/61</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bowman's Chapel Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cassville, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>AUG 28 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9314

CERTIFICATE OF DEATH

09305

Item 2 Film 6293 8/22/61 mh

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium + Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE California b. COUNTY FRANCE/GEORGE c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Marblehead Berkley d. STREET ADDRESS 78 Sunnyside Rd. Point Branch Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Elizabeth Kidder		4. DATE OF DEATH Aug. 10 1961	
5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-10-81 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months 7 Days 14 IF UNDER 24 HRS. Hours 10 M'n 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Minnesota	
13. FATHER'S NAME Fred H. Schriber		14. MOTHER'S MAIDEN NAME Esther Wheat	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT Address 254 Carroll St. NW, Wash, DC	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH 24 hrs (approx)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCT					
DUE TO (b) EMBOLISM					
DUE TO (c) GENERALIZED ATHEROSCLEROSIS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 31 JULY 1961 , to 8-10-1961 , that (I) (we) last saw the deceased alive on 8-10-1961 , and that death occurred at 6:05 PM , from the causes and on the date stated above.					
22a. SIGNATURE Morrill C. Quinnam Jr. M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MORRILL C. QUINNAM JR.		22d. ADDRESS 7600 CARROLL AVE. TAKOMA PARK			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/11/61	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges County, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters - 254 Carroll St. NW, Wash, DC		25a. REC'D BY REGISTRAR 11/1/61		25b. REGISTRAR'S SIGNATURE William S. Hanna	

TO HOSPITAL OR AT HOME: The law requires that this certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9315

09306

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Kentucky b. COUNTY Anchorage		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN TB 39 days		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital			d. STREET ADDRESS Anchorage		
3. NAME OF DECEASED (Type or print) Francis Sebastian Kieren			4. DATE OF DEATH Month Day Year August 23 19 61		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-88		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer			10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps		11. BIRTHPLACE (County & State, or foreign country) Michigan
13. FATHER'S NAME Conrad Kieren			14. MOTHER'S MAIDEN NAME Marie Gagnon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes			16. SOCIAL SECURITY NO. 406 03 5280		
18. CAUSE OF DEATH (Enter only one cause; give one for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)		
20h. (State)			20i. (City or town)		
20j. (County)			20k. (State)		
21. I certify that (this hospital) attended the deceased from July 15, 1961 to August 23, 1961 that (I) (we) last saw the deceased alive on August 23, 1961, and that death occurred at 9:50 PM, from the causes and on the date stated above.					
22a. SIGNATURE [Signature]			22b. DATE SIGNED August 24, 1961		
22c. PHYSICIAN'S NAME (Type) D. P. OSBORNE, CAPTAIN, MC, USN			22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 28 August 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington		23e. (State) Va.		25a. REC'D BY REGISTRAR DATE AUG 28 '61	
24. PUBLIC HEALTH DIRECTOR'S SIGNATURE Robert A. Humphrey		24b. ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

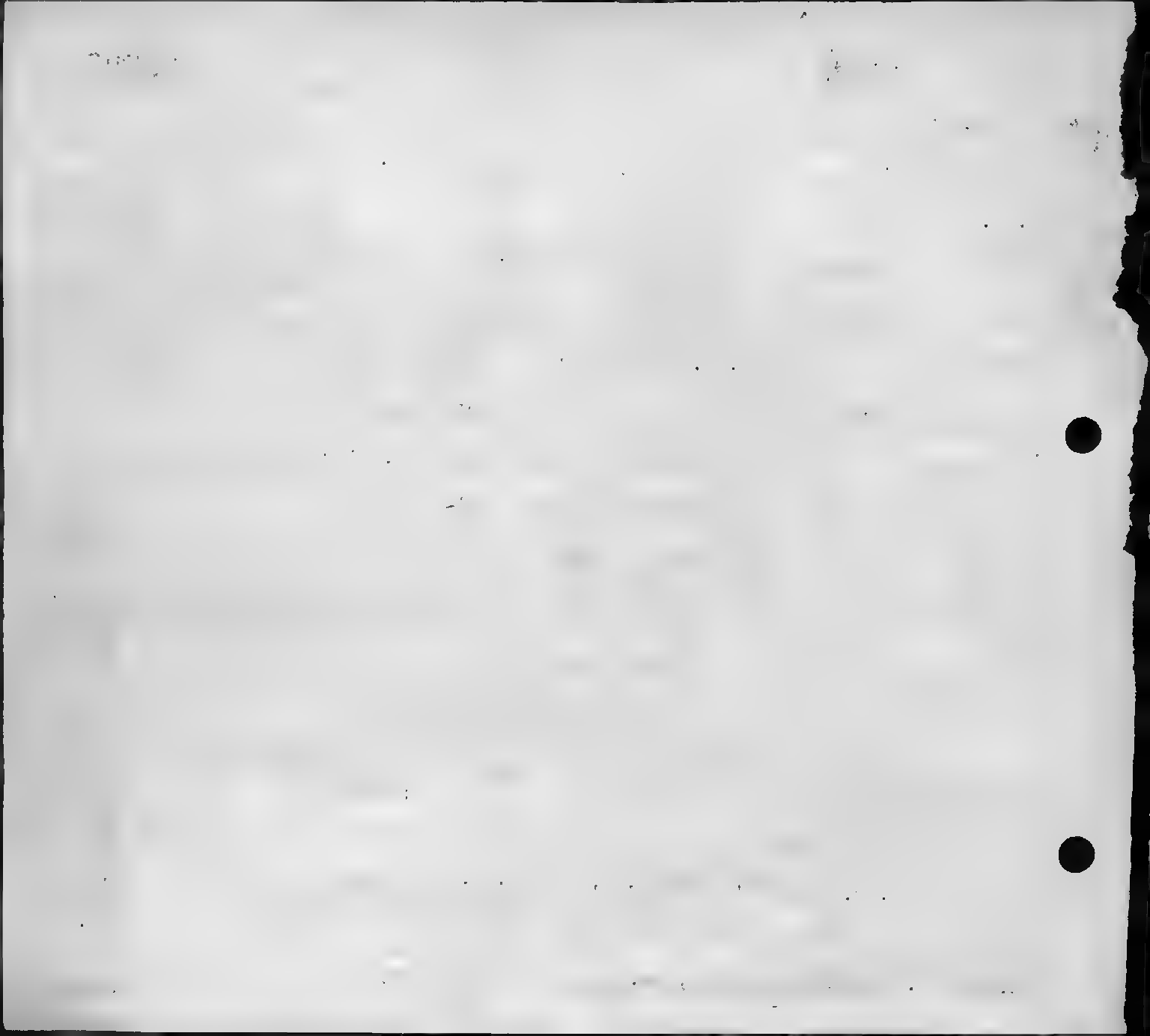
INTERVAL BETWEEN ONSET AND DEATH

5 hrs.

2 yrs

3 1/2 yrs

opt. of Health prior to burial, cremation, or removal, and in any event, 72 hours after death.

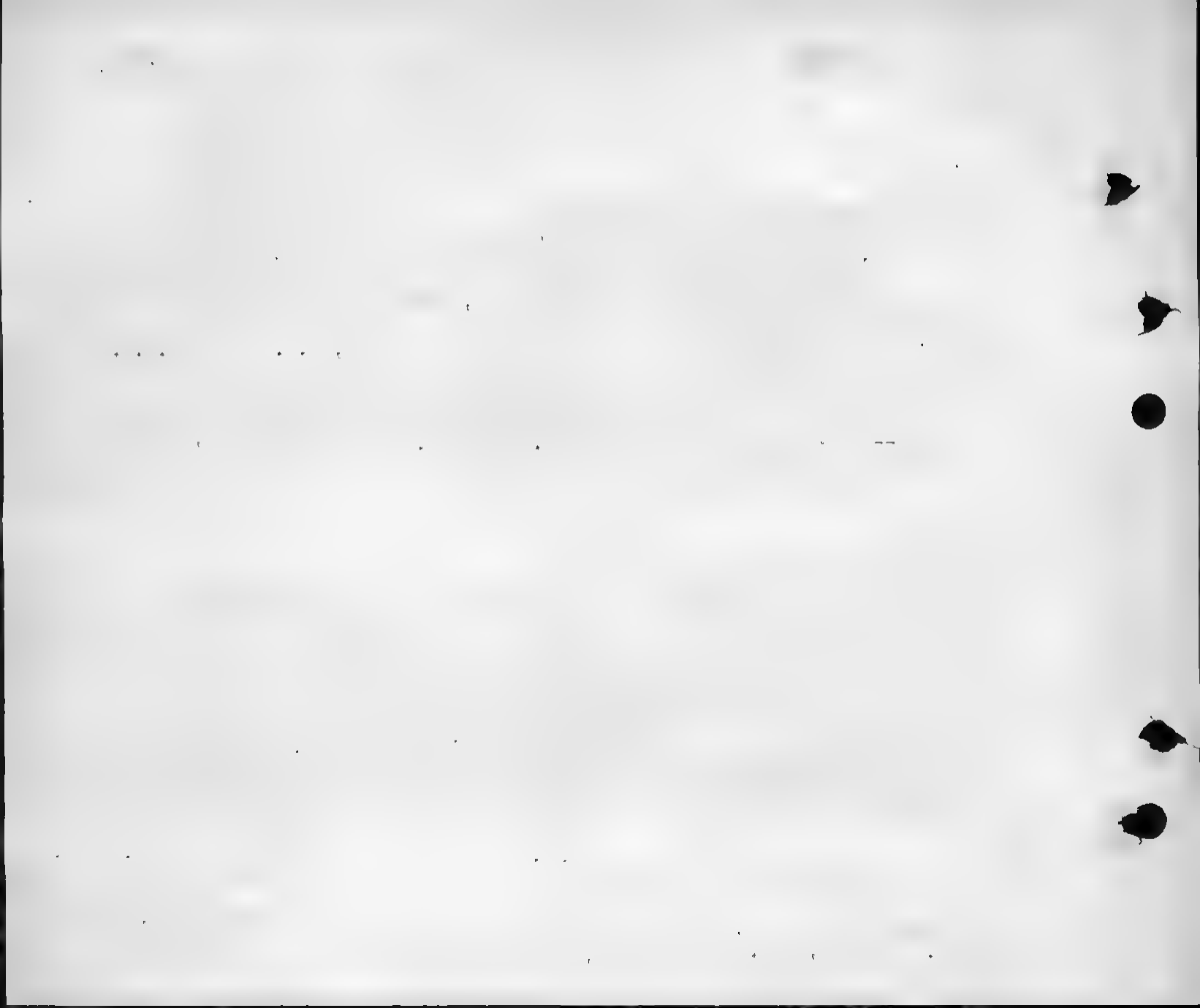


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9316 CERTIFICATE OF DEATH 09307

1 PLACE OF DEATH a. COUNTY Montgomery M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b four days		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 3112 McComas Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Bertha Alice KIRK		4. DATE OF DEATH Month Day Year Aug 19 1961	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 12, 1886
9 AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (State or foreign country) Randolph County, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Addison Albred		14. MOTHER'S MAIDEN NAME Rebecca Elizabeth Connor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16 SOCIAL SECURITY NO. 3213 Green	
17 INFORMANT Mrs. Robert F. Grant		Address Burtonsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Congestive Heart Failure DUE TO (c) Anterior Sclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 36 hours 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 16 1961 to Aug 19 1961 , that (I) (we) last saw the deceased alive on Aug 19 1961 , and that death occurred at 8:30 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau M.D.		22b. DATE August 19, 1961	
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		22d. ADDRESS 10609 Concord Street, Kens., Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/61	
23c. NAME OF CEMETERY OR CREMATORY Colesville Cemetery		23d. LOCATION (City, town, or county) (State) Colesville, Montgomery, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25a. REGISTRAR'S SIGNATURE Arthur S. Knaul	
ADDRESS 8454 Georgia Avenue Silver Spring, Maryland		25b. REC'D BY REGISTRAR DATE AUG 24 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for filing as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9317
CERTIFICATE OF DEATH

09308

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>1 day 14 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1536 Rhode Island Ave. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willie J. Knight</u> First Middle Last 4. DATE OF DEATH <u>August 17, 1961</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>December 17, 1896</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE, in years (last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard Force G.I.A. - Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Willie J. Knight</u> 14. MOTHER'S MAIDEN NAME <u>Susie Belding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Hospital Chart</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> DUE TO (b) <u>carcinoma of the lung</u> DUE TO (c) <u>162X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>1960</u> to <u>8/16</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/16</u> , 19 <u>61</u> , and that death occurred at <u>4:55</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Hugh W. Iney</u> 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7105 Riggs Road, Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>8/19/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>		25a. REC'D BY REGISTRAR <u>2901-1444</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> DATE <u>AUG 21 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

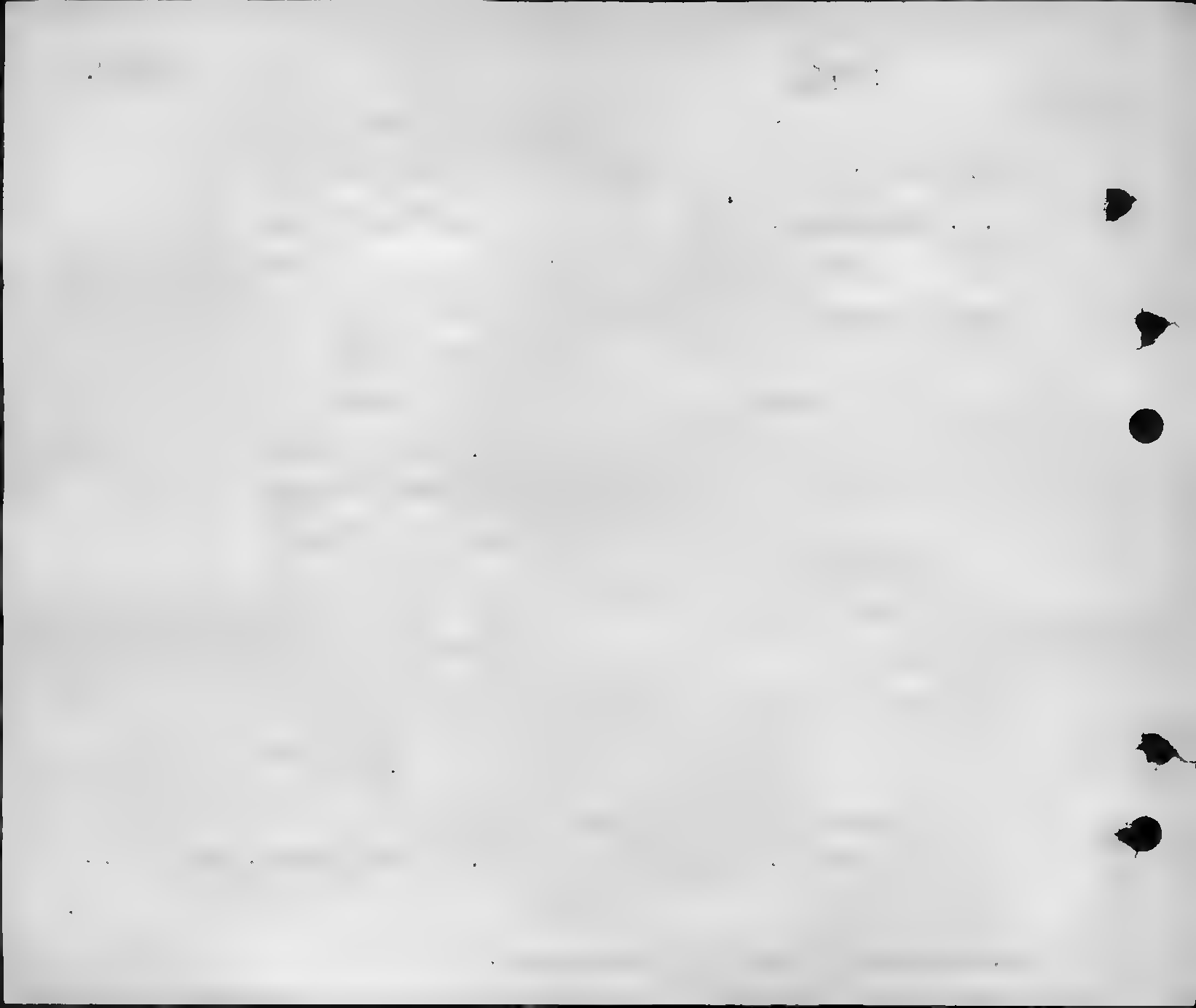
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9318

09309

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY North Carolina c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jacksonville d. STREET ADDRESS 331 Eastwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael Dean Kratzer		4. DATE OF DEATH August 7 1961		9. AGE (in years last birthday) 1 Months 18 Days IF UNDER 1 YEAR 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-20-61		9. AGE (in years last birthday) 1 Months 18 Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David Harrison Kratzer	
14. MOTHER'S MAIDEN NAME Loretta Torrente		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or details of service) No		16. SOCIAL SECURITY NO. David H. Kratzer	
17. INFORMATION Same as #2 above		18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 754.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1/1 DUE TO Congenital heart disease, (coarctation of aorta)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) August 3 1961 to August 7 1961		20g. (County) August 7 1961	
20h. (State) August 7 1961		21. I certify that (this hospital) attended the deceased from August 3 1961 to August 7 1961 , that (we) last saw the deceased alive on August 7 1961 and that death occurred at 10:35 AM from the causes and on the date stated above.		22a. SIGNATURE Robert V. Rack M.D. 22b. DATE SIGNED 8-6-61	
22c. PHYSICIAN'S NAME (Type) Robert V. Rack, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 8-11-61		23c. NAME OF CEMETERY OR CREMATORY Haly Sepulchre		23d. LOCATION (City, town or county) Philadelphia Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave. Bethesda, Md.		25a. REC'D BY REGISTRAR DATE AUG 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



9319

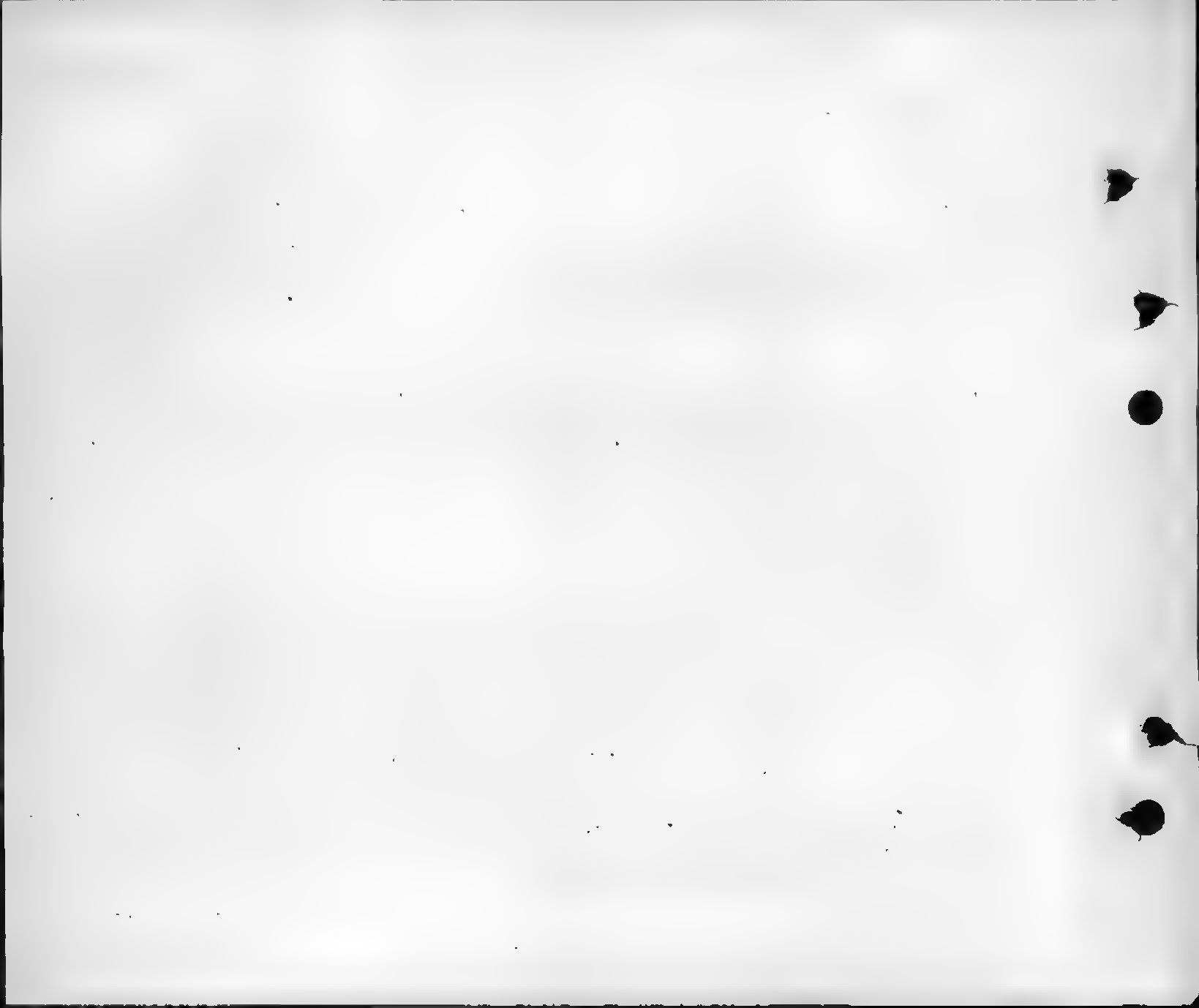
CERTIFICATE OF DEATH

Reg. Dist. No. 9310

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY Y	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1078 RUATAN ST.		d. STREET ADDRESS 1078-RUATAN, ST	
3. NAME OF DECEASED (Type or print) SIMON First KUZMINSKY Middle LAST		4. DATE OF DEATH AUG. 16- 1961 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1895
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCKR		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME AKIVA KUZMINSKY		14. MOTHER'S MAIDEN NAME CHAYA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 578-34-5096	
17. INFORMANT MORTON KILNER		Address 1078 RUATAN ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 237 IMMEDIATE CAUSE (a) Brain Tumor DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Uremia.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 12, 1961 to Aug 16, 1961 , that I last saw the deceased alive on Aug 15, 1961 , and that death occurred at 10:55 AM , from the causes and on the date stated above			
ACTUAL SIGNATURE Morton Altschuler M.D.		ADDRESS (Street, city or town, state) 9205 New Hampshire DATE SIGNED 8/16/61	
PHYSICIAN'S NAME (Type) Morton Altschuler, M.D.		Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUGUST 17, 1961	22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY	22d. LOCATION (City, town, or county) (State) HYATTSVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Bernard D. [unclear]		24a. REC'D BY REGISTRAR 3501-14 57.11W DATE AUG 24 '61	
24b. REGISTRAR'S SIGNATURE Carlton L. [unclear]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

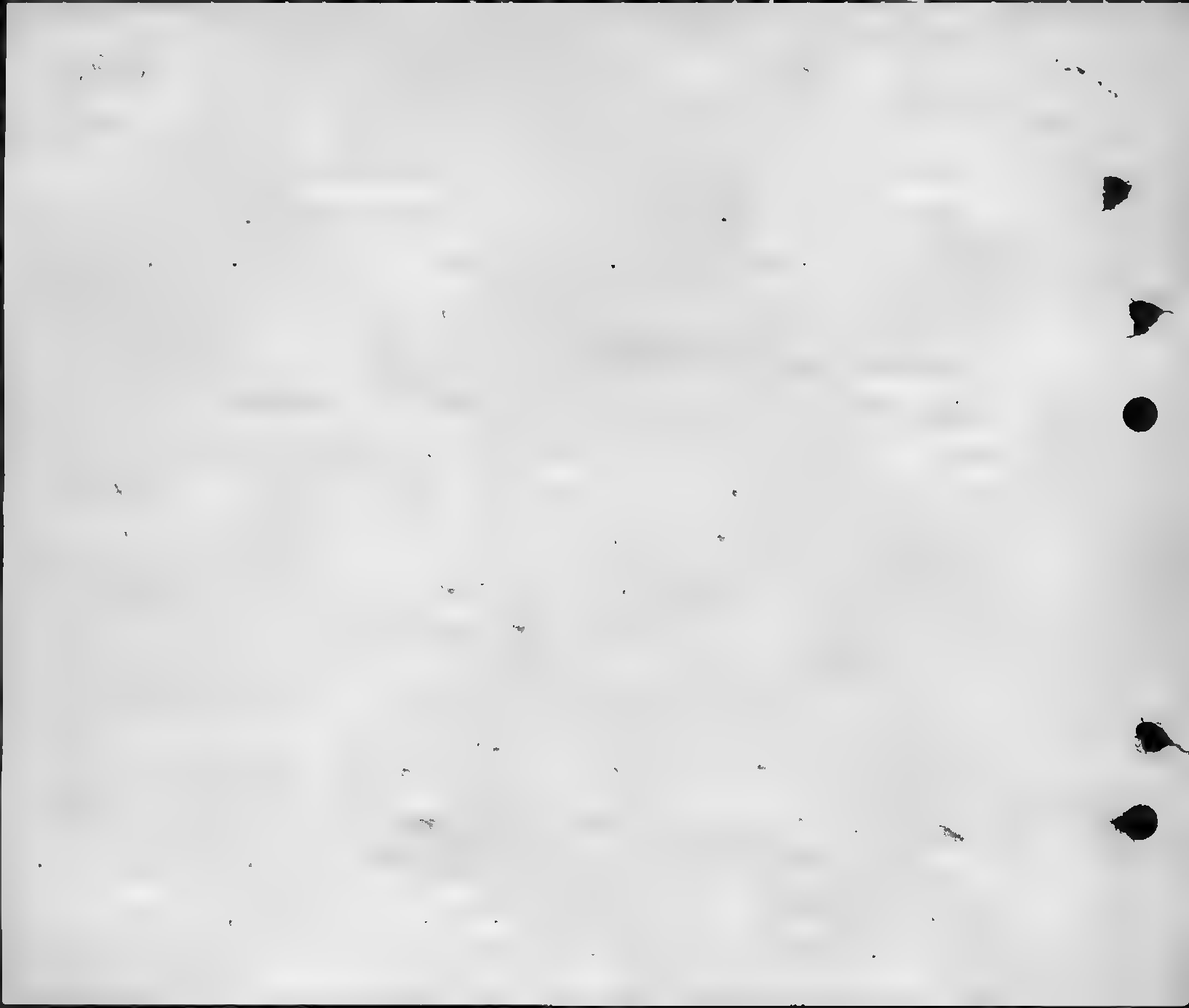
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9320

CERTIFICATE OF DEATH

09311

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Springfield c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address, 5512 Pollard Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Springfield d. STREET ADDRESS 5512 Pollard Rd.	
3. NAME OF DECEASED (Type or print) ROGER A. LaGUARDIA		4. DATE OF DEATH Aug. 5, 1961	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 22, 1925 9. AGE (In years last birthday) 36 yrs. 2 months 13 days 13 hours 13 min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Georgetown Administrative Asst - Hospital 10b. KIND OF BUSINESS OR INDUSTRY New York 11. BIRTHPLACE (Country & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gari LaGuardia		14. MOTHER'S MAIDEN NAME Francesca Sciommari	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. WW 2 17. INFORMANT Barbara M. LaGuardia-wife-same 2d Address 577-30-3188		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last } b) Coronary Thrombosis c) Coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 hrs Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8/2/61 20f. (City or town) Rockville, Md. (County) Arlington (State) Virginia	
21. I certify that (I) (this hospital) attended the deceased from 8/2/61 to 8/5/61 , that (I) (we) last saw the deceased alive on 8/5/61 , and that death occurred at 8:30 PM from the causes and on the date stated above			
22a. SIGNATURE Stephen N. Jones MD		22b. DATE SIGNED 8/7/61	
22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES		22d. ADDRESS 809 Viers Mill Rd., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8/9/61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. 23d. LOCATION (City, town or county) Arlington, Virginia (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR AUG 9 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

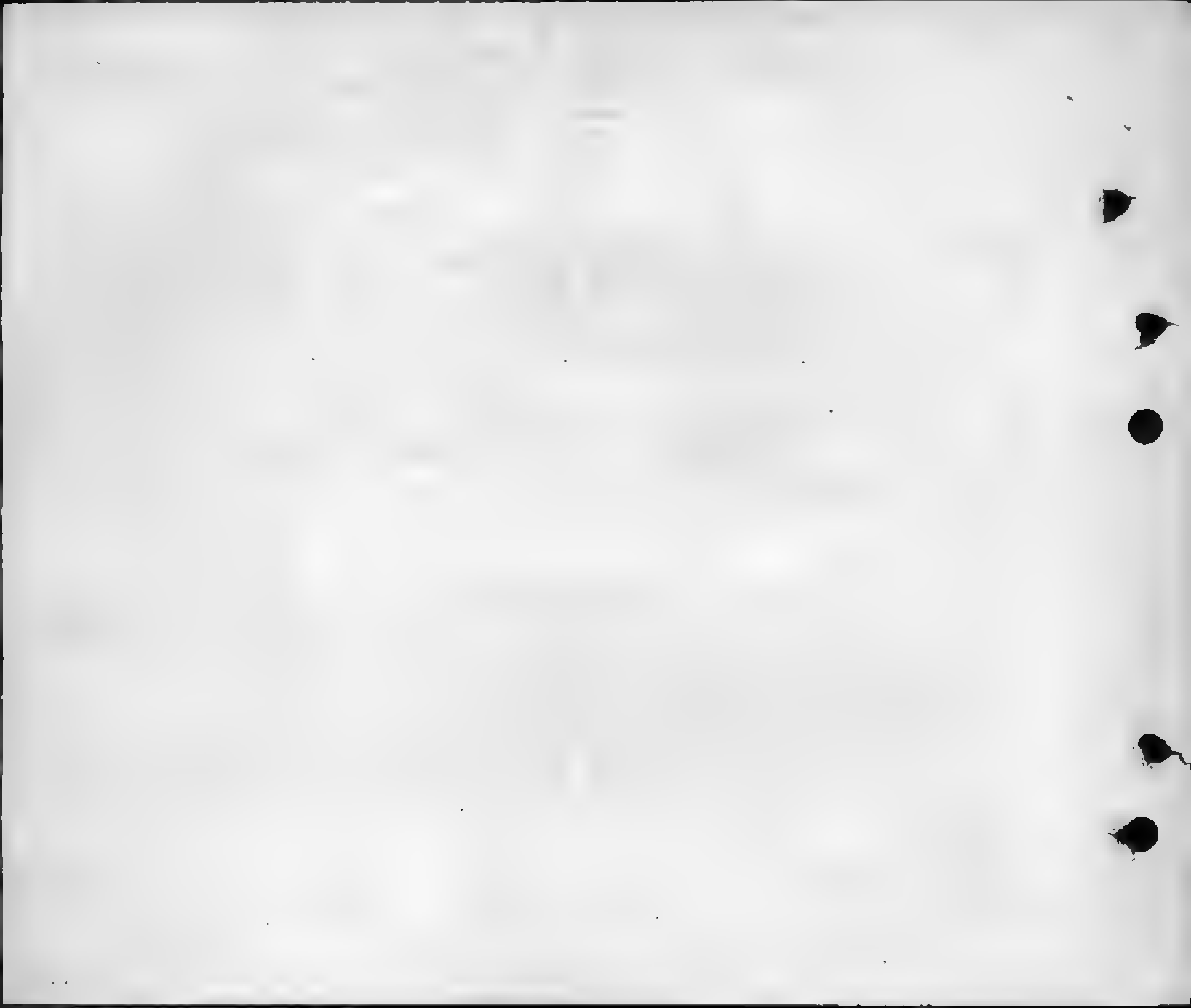
9321

CERTIFICATE OF DEATH

Reg. Dist. No. 09312

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b Since 1937	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6901 Beechwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Ers Last Lamb		4. DATE OF DEATH Month August Day 7 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1886 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney-ret.		10b. KIND OF BUSINESS OR INDUSTRY Patent Atty.	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis A. Lamb		14. MOTHER'S MAIDEN NAME Peharoh Ewin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes Unknown	
17. INFORMANT Bill Lamb-son-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CACHEXIA and Exhaustion 152.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). CARCINOMA of the Sigmoid DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 6 Mo 5 YRS		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 28, 1949 to AUG 7, 1961 , that I last saw the deceased alive on AUG 6, 1961 , and that death occurred at 12:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Horace H. Custis JR		DATE SIGNED 8/7/61	
PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR		ADDRESS (Street, city or town, state) 1852 Columbia Rd. N.W. Washington DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8/7/61	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 9 '61		24b. REGISTRAR'S SIGNATURE Clara S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

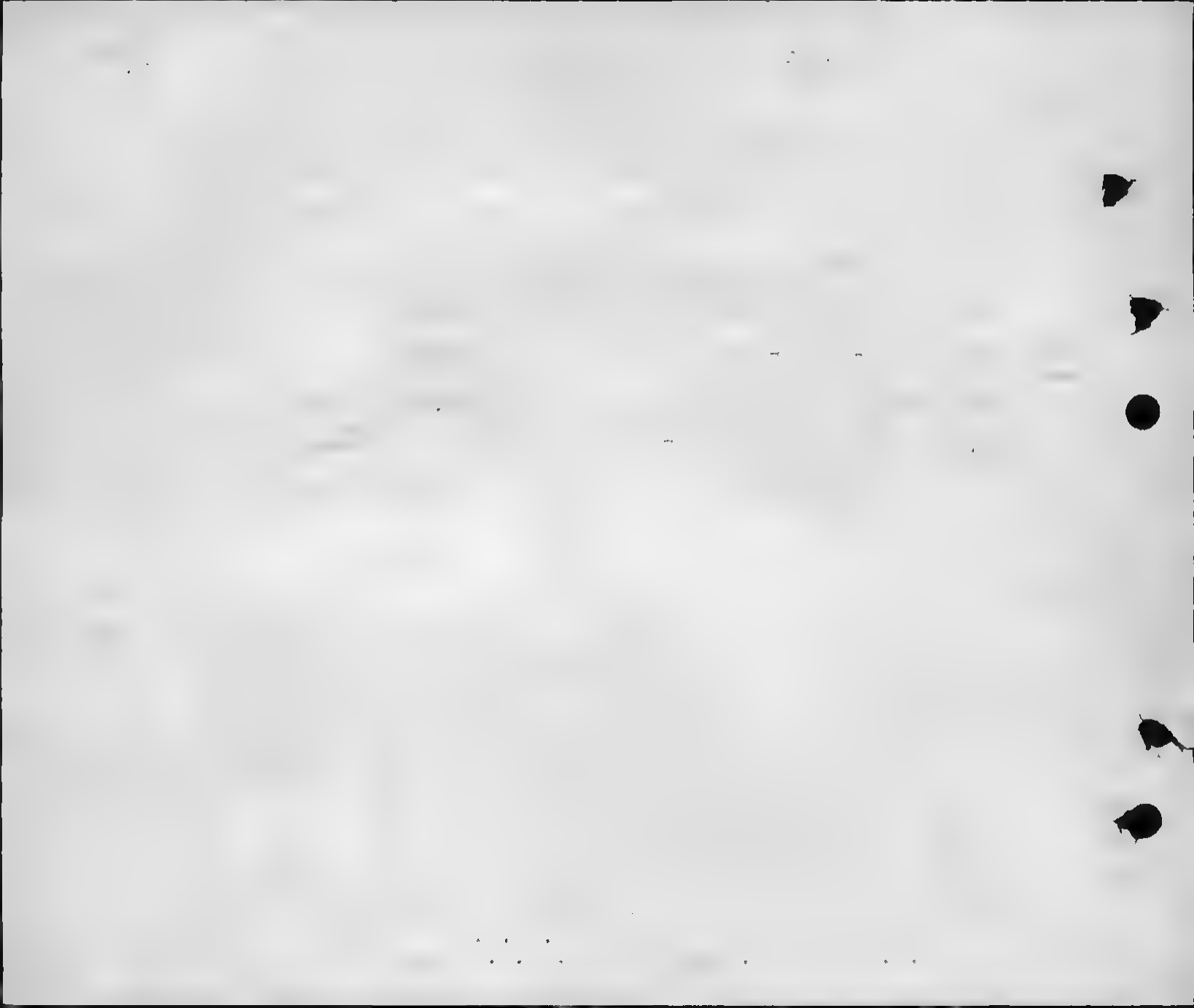


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M

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
9322		9313	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY Montgomery	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	a. STATE Md.	b. COUNTY Montgomery
c. LENGTH OF STAY IN 1b 5 days	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hospital	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	d. STREET ADDRESS 1133 Chickasaw Dr.
3. NAME OF DECEASED (Type or print) George Anthony Lambas		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant-Owner-retired	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 72 yrs.	11. BIRTHPLACE (County & State, or foreign country) Greece
12. CITIZEN OF WHAT COUNTRY USA	13. FATHER'S NAME Anthony Lambas	14. MOTHER'S MAIDEN NAME Anna Vlissidis	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No
16. SOCIAL SECURITY NO. 578001-8345	17. INFORMANT Hospital Records	18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes mellitus & Ulceriodiabetic Heart disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus & Ulceriodiabetic Heart disease	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 1/2 days	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December 1957 to Aug. 29, 1961 , that (I) (no) last saw the deceased alive on Aug. 28, 1961 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Russell B. Arnold		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.		22d. ADDRESS 8801 Cokesville Road, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/1/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
25b. REGISTRAR'S SIGNATURE SEP 1 '61		25c. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Bp



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be reviewed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

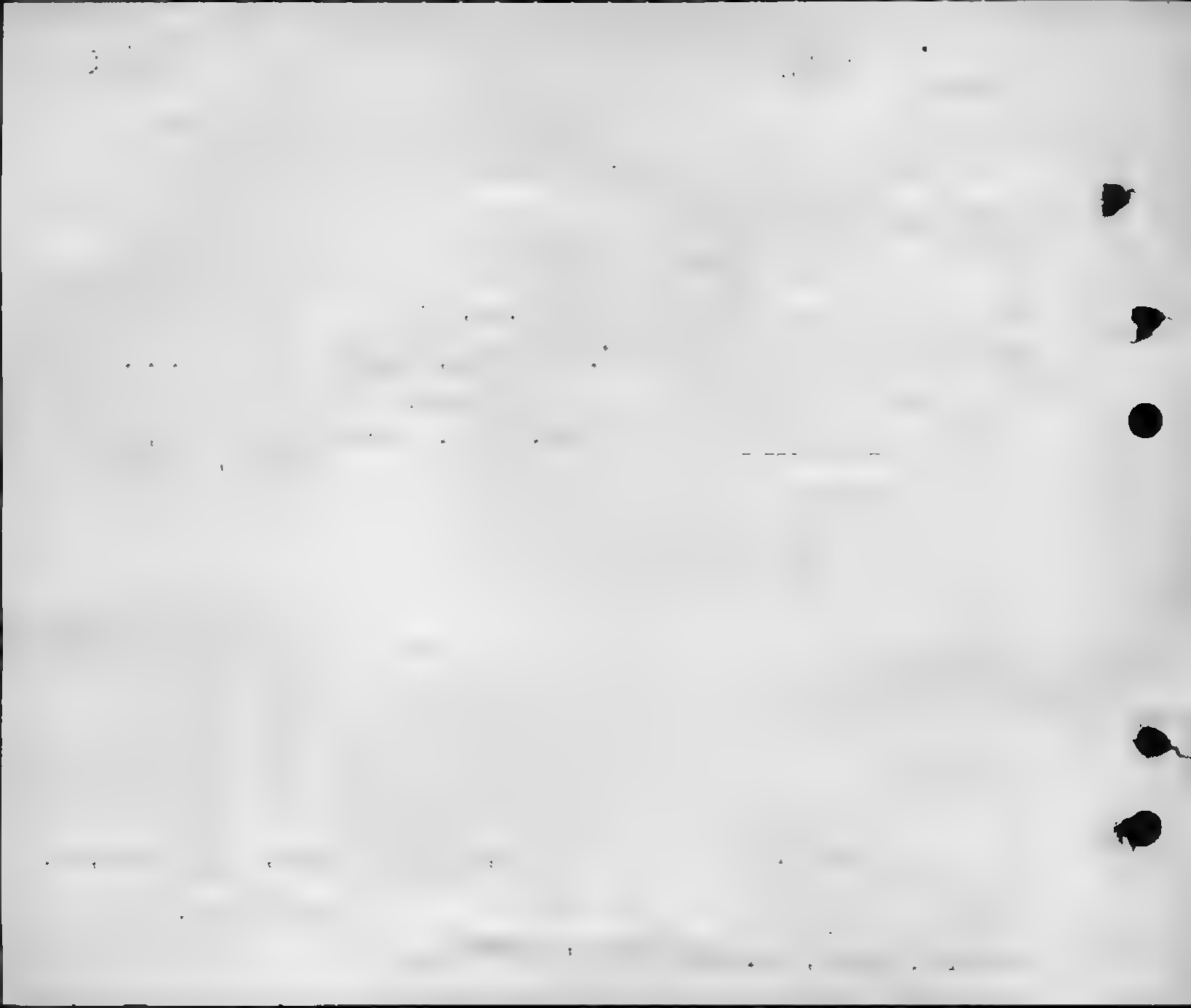
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9323

CERTIFICATE OF DEATH

09314

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN TB Two years		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 1602 Dublin Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RICHARD JOHN LAVERY		First		Middle		Last		4. DATE OF DEATH Month 8 Day 2 Year 1961		5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. AGE (In years, if under 1 year, last birthday) Months Days Hours Min 83 yrs		9. BIRTHPLACE (Country & State, or foreign country) Chicago, Illinois		10. BIRTH DATE Oct. 20, 1877		11. BIRTHPLACE (Country & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Lavery		14. MOTHER'S MAIDEN NAME Mary Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) None					
16. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.5 DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ARTERIO SCLEROTIC HEART DISEASE DUE TO 10 YEARS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None - SENSITIVITY		17. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None - SENSITIVITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		21. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10,011 Georgia Avenue, Silver Spring, Md.		23. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from... 1958... to... 8/2... 1961... that (I) (we) last saw the deceased alive on... April... 1961... and that death occurred at... 8/2... 1961... from the causes and on the date stated above.		22a. SIGNATURE Henry W. Stout		22b. PHYSICIAN'S NAME (Type) HENRY W. STOUT		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 8/2/61		22e. ADDRESS 10,011 Georgia Avenue, Silver Spring, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/4/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Montgomery County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		24a. ADDRESS 8434 Georgia Avenue		24b. CITY OR TOWN Silver Spring, Maryland		24c. STATE Maryland		24d. ZIP CODE 20910		24e. REC'D BY REGISTRAR Arthur S. Evans		24f. DATE AUG 7 '61		24g. REGISTRAR'S SIGNATURE Arthur S. Evans		24h. ADDRESS 10,011 Georgia Avenue, Silver Spring, Md.			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9324

Item 4 Film G292 8/28/61 ink

09315

1. PLACE OF DEATH a. COUNTY Montg,		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rest Haven Rest Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) John Mills Lawson		4. DATE OF DEATH Month Aug / Day 14 / Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 5th 1886
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 10 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired. Auster.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Lee's Burg. Va.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John W. Lawson		14. MOTHER'S MAIDEN NAME Rebecca Mills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 213 16 2968	
17. INFORMANT Grace E. Partin. Rockville. Md.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Carcinoma of Pancreas DUE TO (c) Metastasis to bones of Pelvis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , to 8/14 , 19 61 , that (I) (we) last saw the deceased alive on 8/13 , 19 61 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Luciano I. Ledl		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Luciano I. Ledl		22d. ADDRESS Gaithersburg, Md	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-16-61	
23c. NAME OF CEMETERY OR CREMATORY Lake View		23d. LOCATION (City, town or county) (State) Hamilton. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		25a. RECEIVED BY REGISTRAR AUG 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9325

09316

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>500 Greenlawn Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES WARD LAWYER</u> 5 SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 19-1889</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> 1961		4. DATE OF DEATH <u>August 3</u> 1961 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital Records</u> 11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Philip H. Lawyer</u> 14. MOTHER'S MAIDEN NAME <u>Delilah Huttie</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u> 17. INFORMANT <u>Hospital Records</u> Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420 IMMEDIATE CAUSE (a) <u>Longestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis, acute. Bronchiectasis. Emphysema.</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER!) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1961, to Aug. 3, 1961, that (I) (we) last saw the deceased alive on Aug. 2, 1961, and that death occurred at 12:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Seruch T. Kimble</u> 22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u> M.D.		22b. DATE SIGNED <u>3 Aug 61</u> 22d. ADDRESS <u>927 Pennington, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>8/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> 23d. LOCATION (City, town & county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Vincent</u> ADDRESS <u>2525 Bladensburg Rd Wash DC</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

on the spot, in the late 19th

century, the town of (6) 1902

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MARYLAND STATE DEPARTMENT OF HEALTH

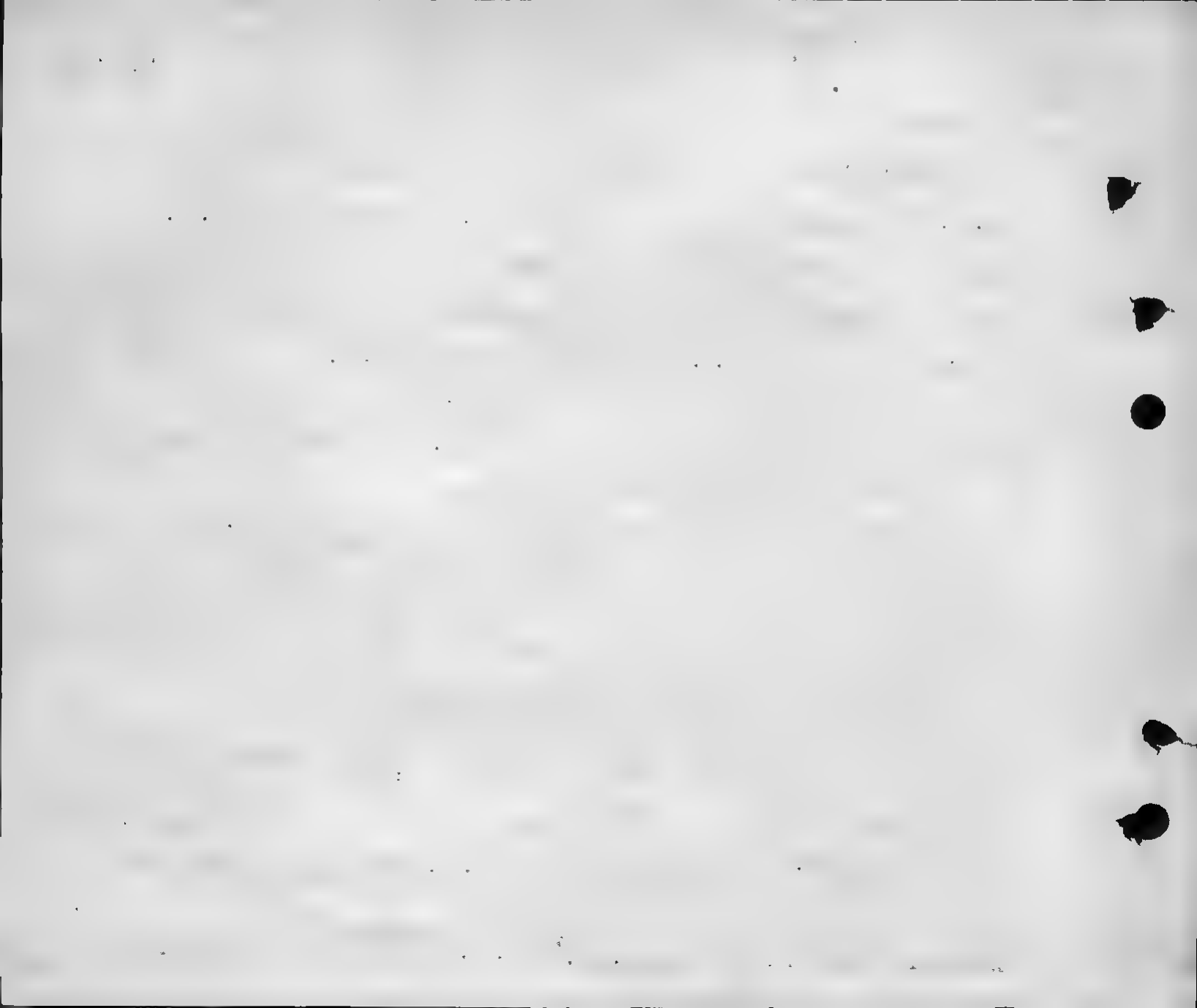
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09318

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN IS 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1555 Fort Dupont St. N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Landreville First Middle Last 5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1-22-98 9. AGE in years 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		4. DATE OF DEATH August 13 1961 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY USA 13. FATHER'S NAME Onesime LeDoux 14. MOTHER'S MAIDEN NAME Ida M. Howe 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II 16. SOCIAL SECURITY NO. 17. INFORMANT Bertha T. LeDoux Address Same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma Conditions if any, which gave rise to immediate cause (b) Cirrhosis Liver, Laennec's Type (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 31 1961 to August 13 1961 that (s) (we) last saw the deceased alive on August 13 1961 , and that death occurred at 8:50 PM from the causes and on the date stated above.			
22a. SIGNATURE John M. Lewis LCDR, MC USN		22b. DATE August 14, 1961	
22c. PHYSICIAN'S NAME (Type) JOHN M. LEWIS, LCDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 17, 1961	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington Va.
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, Inc.		25a. REG. NO. 46676	25b. REGISTRAR'S SIGNATURE Arthur S. Knease

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

24 hours after death. If any delay is necessary, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the certificate. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. If Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 9 Film G292 8/10/61											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN Bldg. <u>1 day</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Woodley Garden Office Bldg.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. COUNTY <u>Montg</u>			
3. NAME OF DECEASED (Type or print) <u>Thomas Girard Lee</u>				d. STREET ADDRESS <u>9310 Burning Tree Rd</u>				g. DATE OF DEATH <u>Aug 1 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>1908</u>		9. AGE (If under 1 year, give last birthday) <u>53</u>		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Const. Co.</u>				11. BIRTHPLACE (State or foreign country) <u>D.C.</u>			
13. FATHER'S NAME <u>Walter H. Lee</u>				14. MOTHER'S MAIDEN NAME <u>Sarah W. Washington</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-36-2777</u>				17. INFORMANT <u>T. Girard Lee, Jr. (SON)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>351X</u> DUE TO <u>Permeation of Brain Stem</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intra-ventricular cerebral hemorrhage</u>											
(c) <u>Sudden</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Sudden</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
21. ACTUAL SIGNATURE <u>Frank J. Broscham</u>				21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				21. DATE SIGNED <u>8-2-61</u>			
21. EXAMINER'S NAME (Type) <u>FRANK J. Broscham</u>				21. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
21. ADDRESS (Street, city, town, or county)				21. ADDRESS (Street, city, town, or county)				21. ADDRESS (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/4/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			
22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>				22e. REC'D BY REGISTRAR <u>AUG 7 '61</u>				22f. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				23. ADDRESS <u>Bethesda, Maryland</u>							



9329

CERTIFICATE OF DEATH

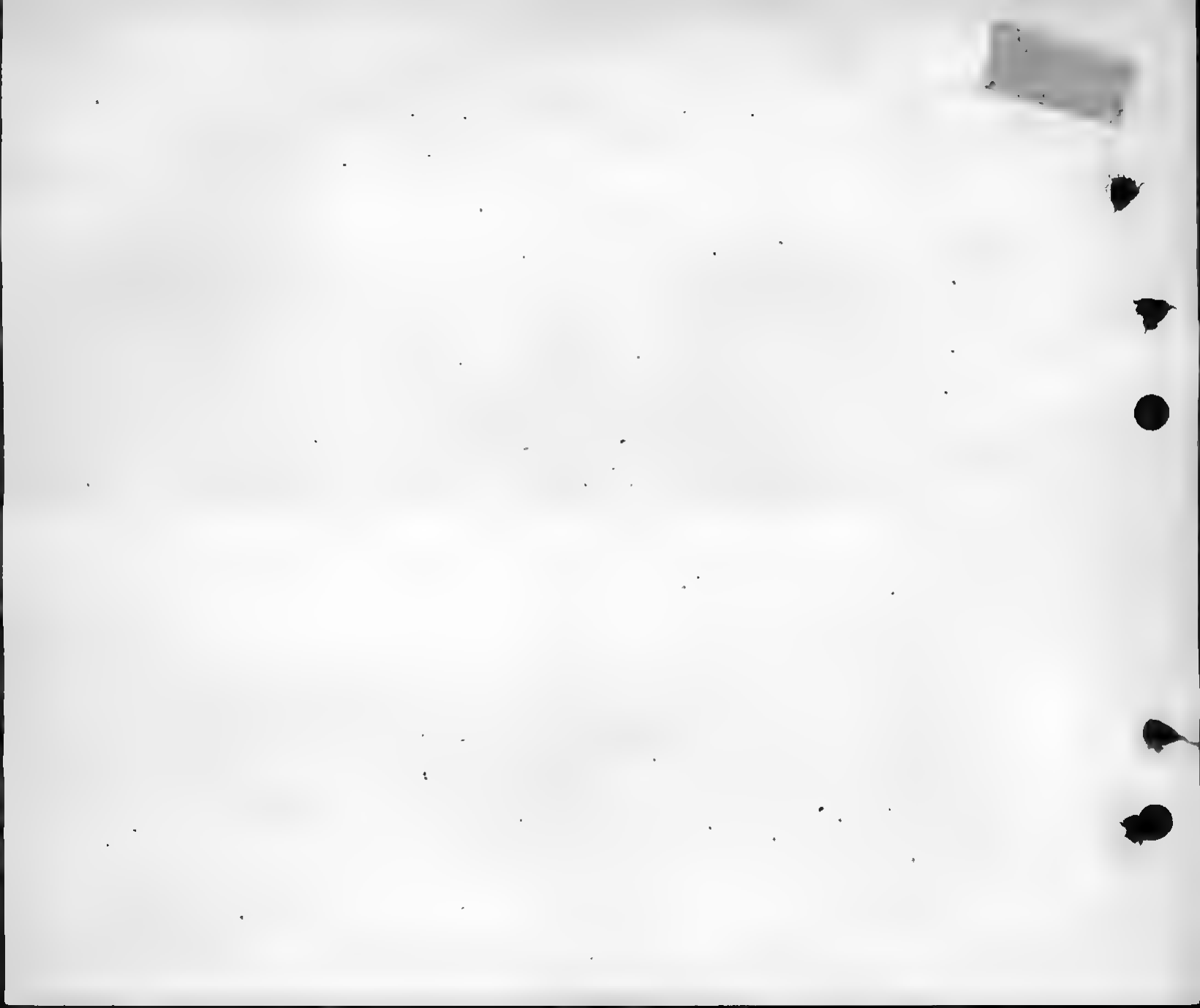
Reg. Dist. No. 09320

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If instituting: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanitarium</u>		d. STREET ADDRESS <u>5415 Conn Ave NW</u>	
3. NAME OF DECEASED (Type or print) <u>Goodrich W Lineweaver</u>		4. DATE OF DEATH <u>Aug 8 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1887</u>
9. AGE (In years, last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>4</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Madison</u>		14. MOTHER'S MAIDEN NAME <u>Sally Ralston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Croke-son in law-same 2d</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Essential Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 Mo</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 28 1957</u> to <u>Aug 6 1961</u> , that I last saw the deceased alive on <u>Aug 6 1961</u> , and that death occurred at <u>7:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Herbert Bauersfeld</u>		ADDRESS (Street, city or town, state) <u>1912 R St NW Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>E. Herbert Bauersfeld M.D.</u>		DATE SIGNED <u>8/9/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>AUG 14 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The funeral director, or the hospital or attending physician, may be required to sign the certificate. After this certificate has been signed by the attending physician and completely filled in, the funeral director, or the hospital or attending physician, may be required to sign the certificate. After this certificate has been signed by the attending physician and completely filled in, the funeral director, or the hospital or attending physician, may be required to sign the certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or the hospital or attending physician, may be required to sign the certificate. After this certificate has been signed by the attending physician and completely filled in, the funeral director, or the hospital or attending physician, may be required to sign the certificate.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9330

CERTIFICATE OF DEATH

09321

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if no. in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE South Carolina f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Spartanburg g. STREET ADDRESS 1063 Boiling Springs Rd. h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Timothy Clark Lister First Middle Last 5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH August 11, 1960 9. AGE (In years last birthday) 11 yrs. 11 months 22 days 00 hours 00 min. 10a. USUAL OCCUPATION (Give kind or work done during most of working life, even if retired) Child 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Japan 12. CITIZEN OF WHAT COUNTRY USA				13. FATHER'S NAME Robert Marchant Lister 14. MOTHER'S MAIDEN NAME Evelyn Elizabeth Kimbrell 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Robert M. Lister Address Same as #2 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 754.0 DUE TO strategy of Feller Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year July 19, 1961 Hour a.m. 12:07 PM p.m. 12:07 PM 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 19, 1961 to August 3, 1961 , that (a) (we) last saw the deceased alive on August 3, 1961 , and that death occurred August 3, 1961 , from the causes and on the date stated above.									
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) R.P. DOBBIE, JR, CDR MC USN				22b. DATE SIGNED 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipment		23b. DATE THEREOF 4 August 1961		23c. NAME OF CEMETERY OR CREMATORY Spartanburg S. C.		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi's Funeral Home, Washington, D. C.				25a. REC'D BY REGISTRAR AUG 7 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9331

CERTIFICATE OF DEATH

09322

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Bethesda</u> d. STREET ADDRESS <u>17809 Tilbury St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mercedes</u> Middle <u>L.</u> Last <u>Little</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>April 24 1878</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>83</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1961</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PARIS, FRANCE</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph P. SAGRARIO</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>218-30-3403</u> (MARGUERITE HOGSWARD)		14. MOTHER'S MAIDEN NAME <u>Josephine B. Ilean</u> 17. INFORMANT <u>Sister</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>331X</u> DUE TO <u>Confluent Arteriovenous aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebrovascular Accident</u> (c) <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1961</u> to <u>Aug 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 7, 1961</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Joseph Kenrick</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. JOSEPH KENRICK</u>		22b. DATE SIGNED <u>Aug 7, 1961</u> 22d. ADDRESS <u>6450 Wisconsin Ave, Bethesda, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>Aug 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05323

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington San & Hospital

USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)

a. STATE

Pennsylvania

b. COUNTY

Centre

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

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e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Jesse

First

Elmer

Livingston

Last

DATE OF DEATH

Month

Day

Year

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED ☐

8. DATE OF BIRTH

8-3-09

9. AGE (In years last birthday)

52 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

University Professor - Head of Dept. Nebraska

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Cyrus L. Livingston

14. MOTHER'S MAIDEN NAME

Elizabeth Spangler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

506-264578

17. INFORMANT

Mrs. William D. Bell

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary atherosclerosis

DUE TO

(b)

DUE TO

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour

s.m.

p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Frank J. Brischart

FRANK J. BRISCHART

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

8-15-61

DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

8/19/61

22c. NAME OF CEMETERY OR CREMATORY

Center County Memorial Park

22d. LOCATION (City, town, or county)

Center County, Pennsylvania

(State)

23. FUNERAL DIRECTOR

Raymond R. Ziska

ADDRESS

8434 Georgia Avenue

Warner E. Pumphrey Inc.

Silver Spring, Maryland

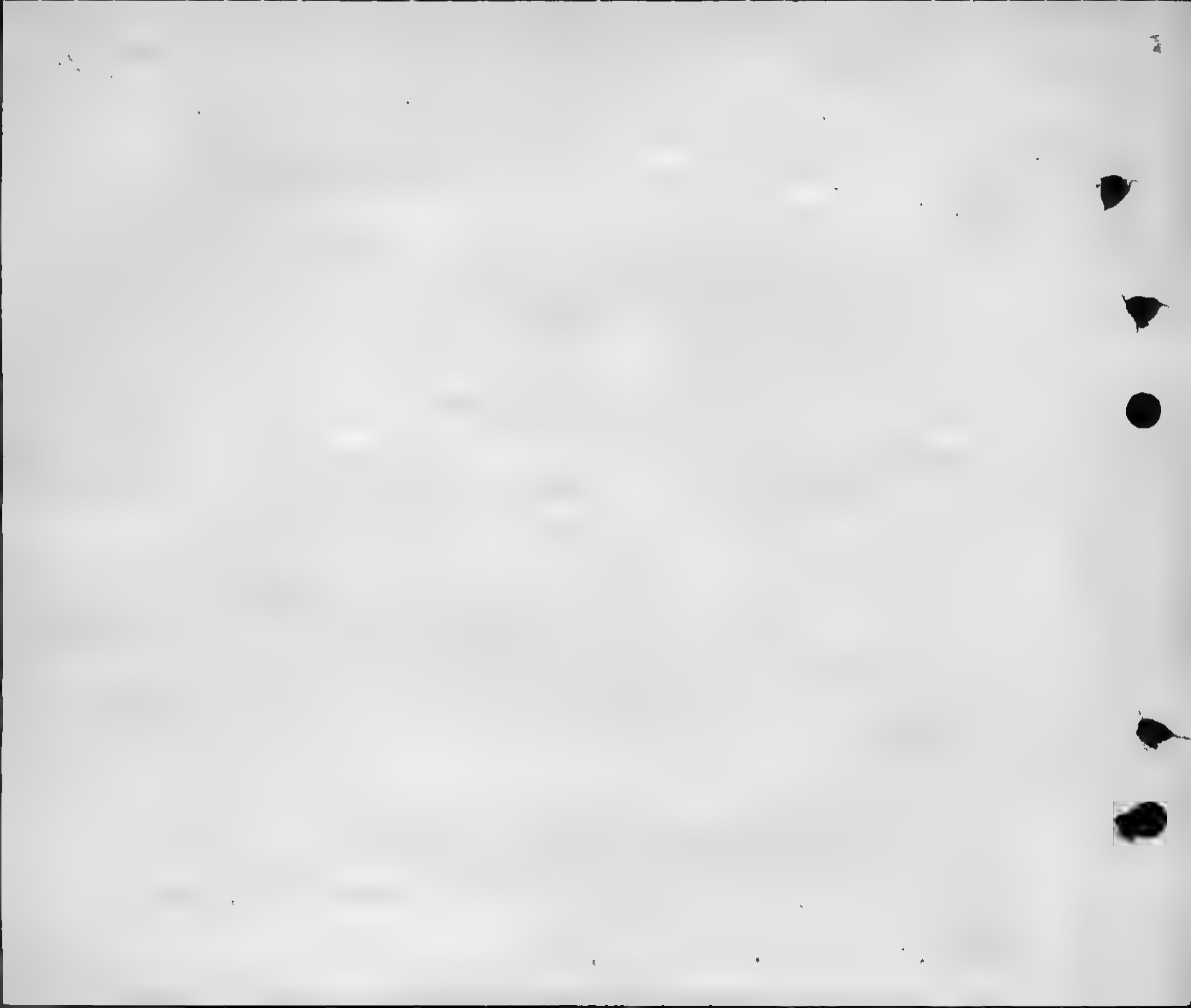
24a. REC'D BY REGISTRAR

AUG 17 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 please be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

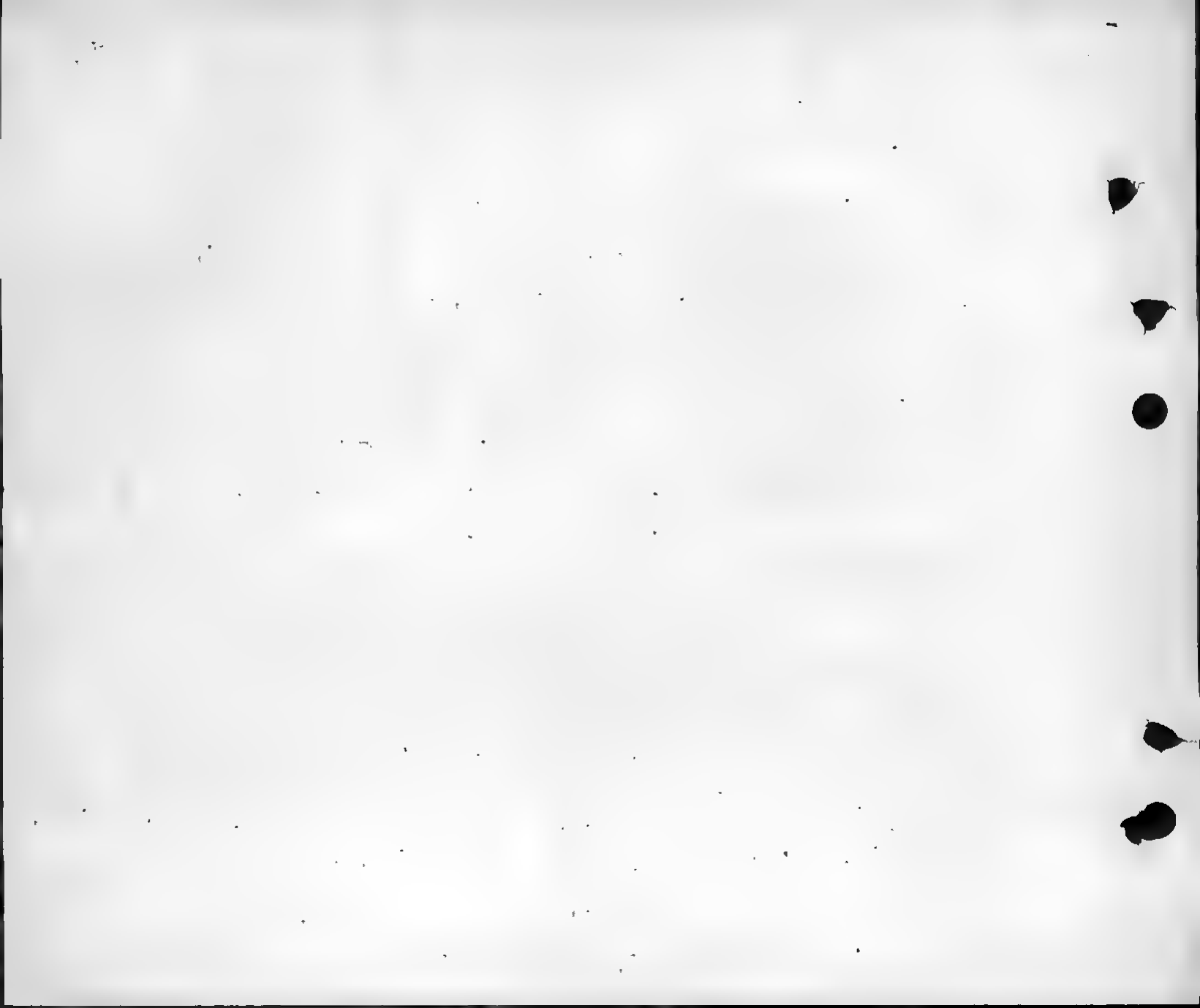
9333

CERTIFICATE OF DEATH

Reg. Dist. No.

09324

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>11</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>703 Gail Avenue</u>		d. STREET ADDRESS <u>703 Gail Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LAURA</u> (M) <u>LIVINGSTON</u>		4. DATE OF DEATH <u>August 17,</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James D. Berry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Duncan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
INFORMANT <u>Maud Livingston-Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 17, 1955</u> to <u>Aug. 17, 1961</u> , that I last saw the deceased alive on <u>Aug. 10, 1961</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Bowditch Hunter, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Veirs Mill Rd</u>	
PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr.</u>		DATE SIGNED <u>8/17/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>8/18/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hickory Point</u>		22d. LOCATION (City, town, or county) (State) <u>Iberia, Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		24a. REC'D BY REGISTRAR <u>AUG 21 '61</u>	
ADDRESS <u>Wheeler Funeral Home-1331 E. Montgomery Ave</u> <u>Rockville, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9334

09325

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

220 Park Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montg.

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. STREET ADDRESS

220 Park Ave.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

3. NAME OF DECEASED

(Type or print)

Jessie

First

Middle

Last

F. Lockwood

4. DATE OF DEATH

Month

Day

Year

Aug. 26

19 61

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED

☐ NEVER MARRIED ☐

☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/26/1871

9. AGE (In years birthday)

90 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Not Available

14. MOTHER'S MAIDEN NAME

Not Available

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

6323 McComb St., N.W.
Olivia McMahon Washington, D.C.

18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Coronary occlusion

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a.

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

While ☐ Not While ☐
a. work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MED. CAL. EXAMINER

8/26/61

DATE SIGNED

EXAMINER'S NAME (Type)

Frank J. Broschart

Address (Street city town or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Aug. 28, 1961

22c. NAME OF CEMETERY OR CREMATORY

Rock Creek Cemetery

22d. LOCATION (City, town, or country)

Washington,

(State)

D.C.

23. FUNERAL DIRECTOR

J. Arthur Walters

ADDRESS

254 Carroll Dr NW

24a. REC'D BY REGISTRAR

AUG 29 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

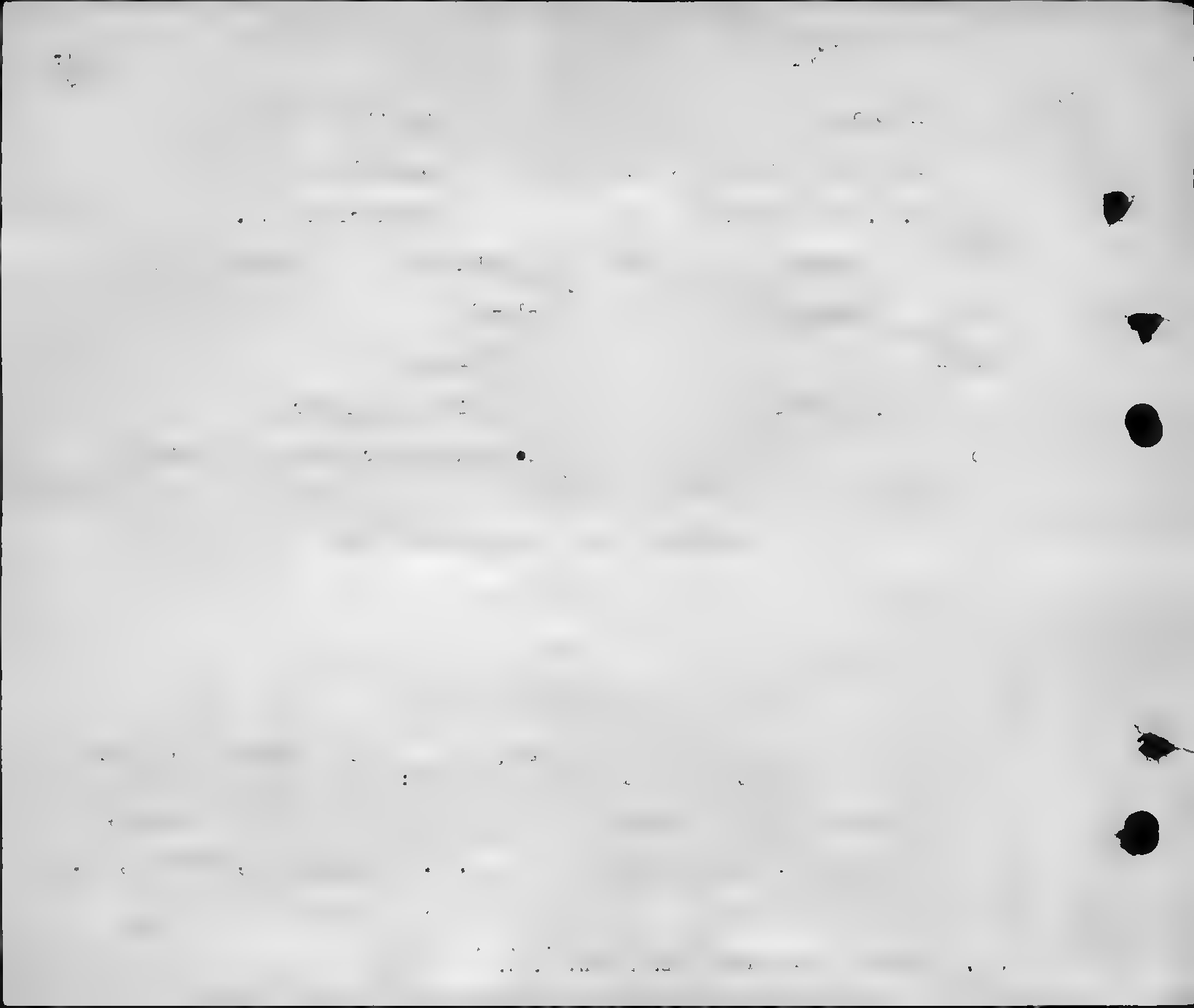
9335

09326

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b. 16 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 806 1/2 Parkwood Ave.	
3. NAME OF DECEASED (Type or print) Tammie Lynn LOUIERE		4. DATE OF DEATH Month August Day 2 Year 19 61	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-16-61	
9. AGE (In years last birthday) 17 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 17 Days 17 Hours 17 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Leo Paul Louviere	
14. MOTHER'S MAIDEN NAME Dianna Lou Mayard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Leo Paul Louviere Same as # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 75 IX DUE TO meningitis DUE TO meningo myelocoele		INTERVAL BETWEEN ONSET AND DEATH 18 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (he) (his) (her) (hospital) attended the deceased from July 17, 1961 to August 2, 1961 that (we) last saw the deceased alive on August 2, 1961 , and that death occurred at 7:45 AM from the causes and on the date stated above.			
22a. SIGNATURE Robert V. Rack		22b. DATE SIGNED August 2, 1961	
22c. PHYSICIAN'S NAME (Type) ROBERT V. RACK, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipment		23b. DATE THEREOF 8-3-61	
23c. NAME OF CEMETERY OR CREMATORY Broussard Cemetery		23d. LOCATION (City, town or county) (State) New Iberia Louisiana	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		25a. REC'D BY REGISTRAR AUG 4 '61	
25b. REGISTRAR'S SIGNATURE W. W. Chambers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

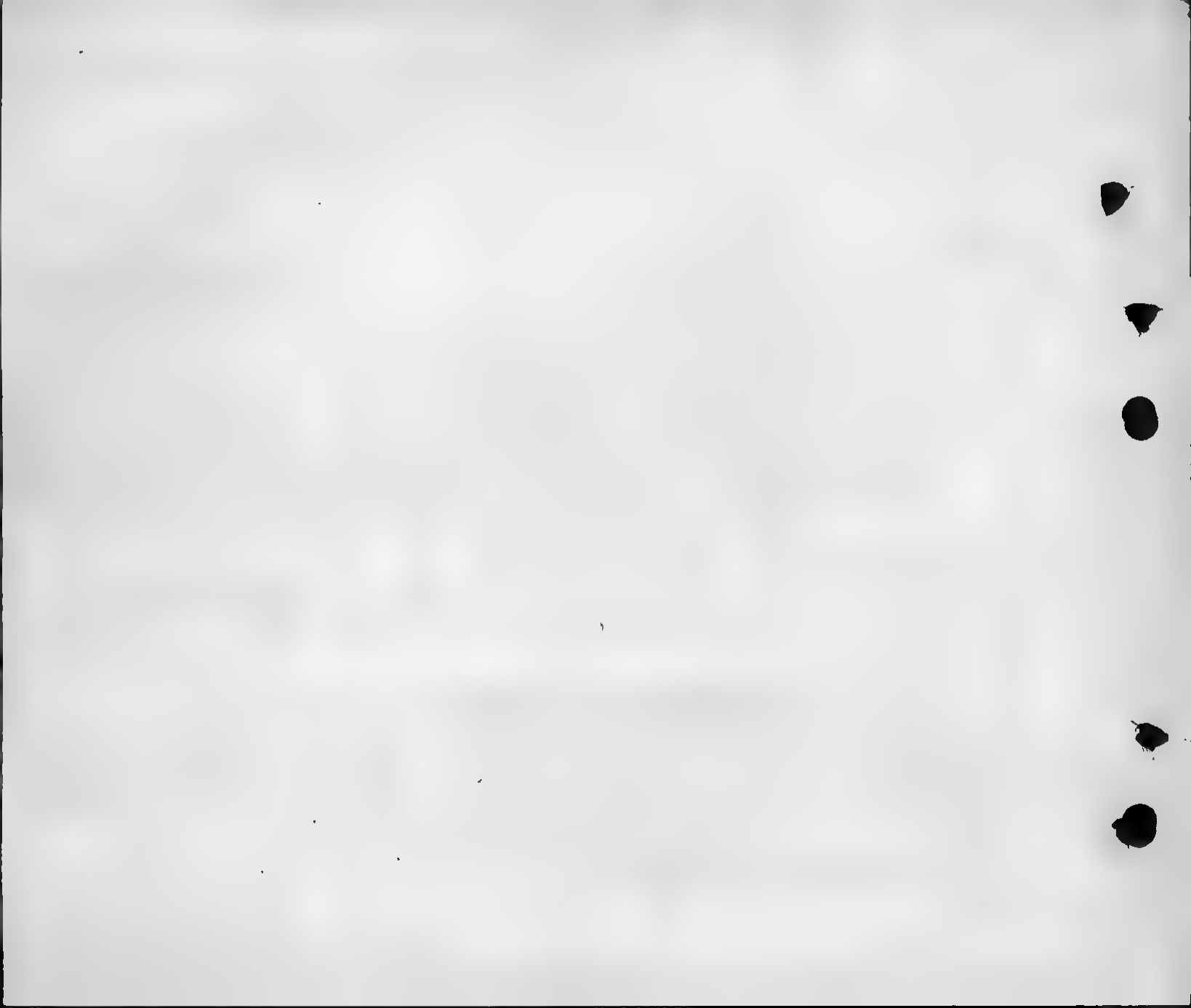
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9336

CERTIFICATE OF DEATH

Reg. Dist. No. 09327

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orlando</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12126 Viers Mill Road</u>				e. STREET ADDRESS <u>Route #2, Box 488 (Natland)</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LENORE</u> Middle <u>P.</u> Last <u>LUSH</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1889</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rosepe M. Harlan</u>				14. MOTHER'S MAIDEN NAME <u>Etta Blanche Brighton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Stephen L. Lush, 12126 Viers Mill Rd. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer in axillary glands; also in r. femur (?)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>61</u> , to <u>Aug. 15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug. 14</u> , 19 <u>61</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrews</u>		M.D. <u>9601 Colesville Rd</u>		ADDRESS (Street, city or town, state) <u>Silver Spring, Md.</u>		DATE SIGNED <u>8-15-61</u>	
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>							
22c. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 17, 1961</u>		22a. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Walters, 254 Carroll St NW, DC</u>				24. REC'D BY REGISTRAR DATE <u>AUG 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. F...</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

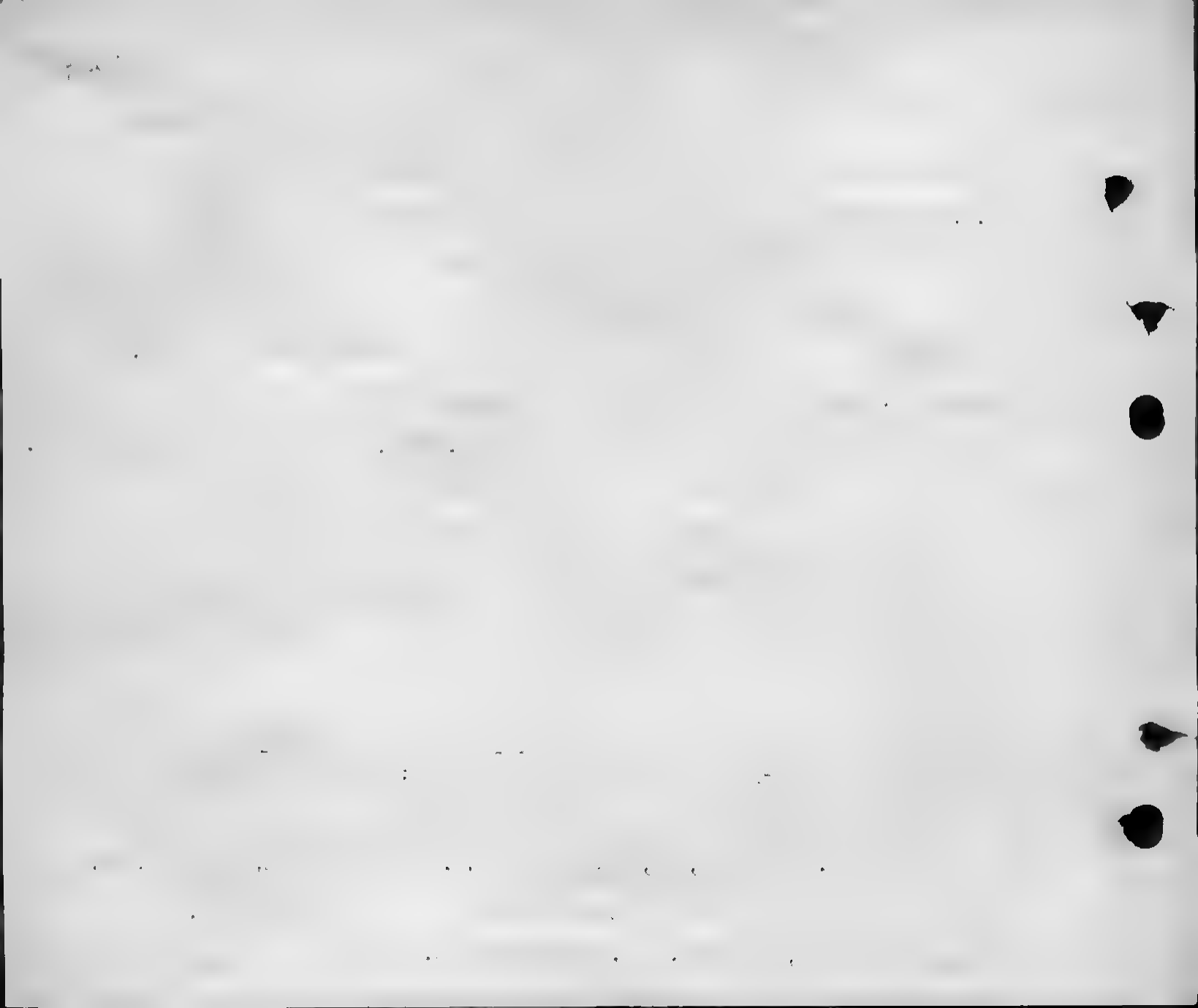
9337

09328

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY in lb <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>U.S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>3216 Toledo Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frederick Carl LUTZ</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-8-76</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. LUTZ</u>		14. MOTHER'S MAIDEN NAME <u>Blandie PFILE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>Richard L. LUTZ, 6709 Bradley Blvd, Bethesda, Md.</u>	
17. INFORMANT <u>Richard L. LUTZ, 6709 Bradley Blvd, Bethesda, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Retroperitoneal hemorrhage</u> DUE TO (b) <u>Ruptured aortic abdominal aneurysm</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) _____ b) _____ c) _____	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour <u>8-5-</u> e.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>8-4-1961 to 8-5-1961</u>	
20f. (City or town) <u>8-5-1961</u>		20g. (County) <u>8-5-1961</u>	
20h. (State) <u>8-5-1961</u>		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.	
22a. SIGNATURE <u>Joseph H. Eusterman</u>		22b. DATE SIGNED <u>8-5-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph H. EUSTERMAN, LT, MC, USN</u>		22d. ADDRESS <u>U.S. NAVAL HOSPITAL, BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 8, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>GASCH FUNERAL HOME, 4739 Balt. Ave. Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>14 AUG 8 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 may be retained by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



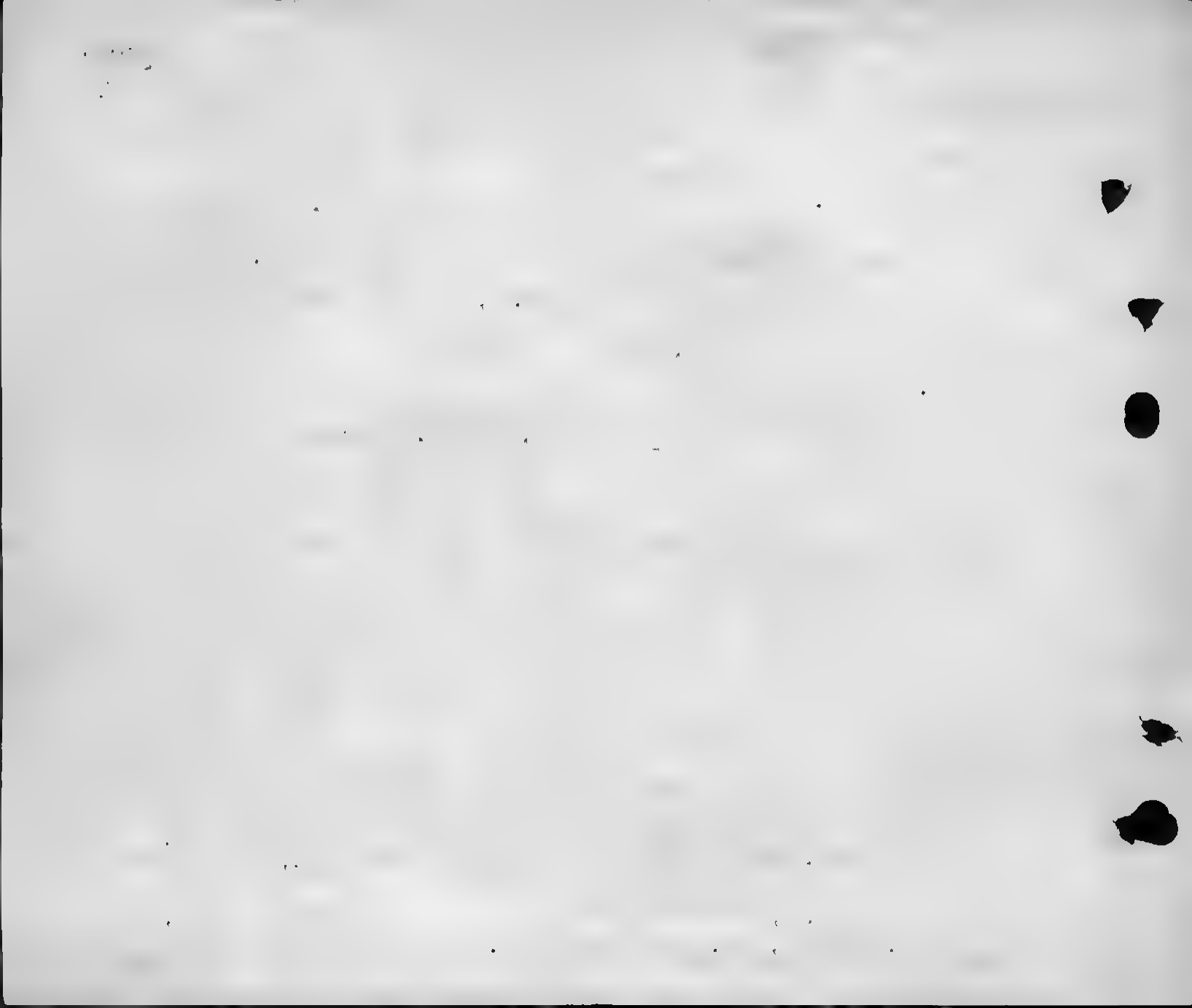
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
3333												
09329												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b. 11 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4202 Dahill Rd.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 4202 Dahill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Clarence Hamilton MacDougal					4. DATE OF DEATH Month AUG. Day 26 Year 19 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 28, 1888		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. For birthday) 73 yrs. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Dept. Store			11. BIRTHPLACE (Country & State, or foreign country) Tennessee			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James H. Mac Dougal					14. MOTHER'S M.A.DEN NAME Annetta Russ							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. 408-07-6210		17. INFORMANT Mrs. Edith G. MacDougal			Address same (wife)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Cancer Metastases to Bones DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 months DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 4 months 2 months					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 10, 1961 to Aug 26, 1961 that (I) (we) last saw the deceased alive on Aug 26, 1961 , and that death occurred at 7:41 AM , from the causes and on the date stated above.												
22a. SIGNATURE John J. Curry					22b. DATE SIGNED 8/26/61							
22c. PHYSICIAN'S NAME (Type) John J. Curry					22d. ADDRESS 10,620 Georgia Ave., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Aug. 28, 1961		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City, town or county) (State) Montgomery County, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska					25a. REC'D BY REGISTRAR AUG 29 '61					25b. REGISTRAR'S SIGNATURE Arthur L. Kneass		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

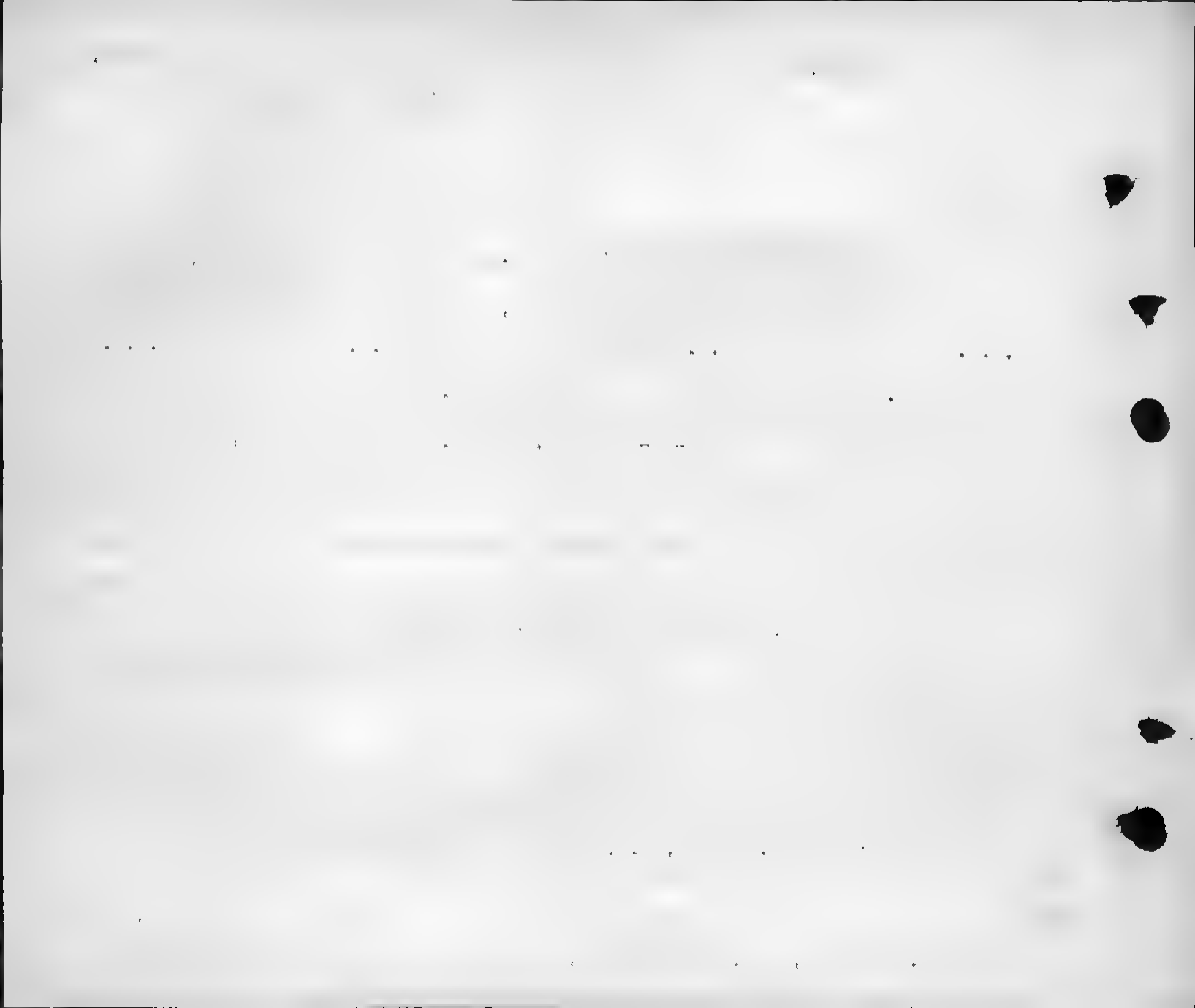
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09330

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 14 YEARS		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTE 3518 NIMITZ ROAD		d. STREET ADDRESS 3518 Nimitz Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Franklin Middle BOVAVENTURE Last Mades		4. DATE OF DEATH Month August Day 16 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1918 29, November	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months 42 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B.M. Operator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Franklin D. Mades		14. MOTHER'S MAIDEN NAME Sarah G. Ray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW2		16. SOCIAL SECURITY NO 577-24-2736		17. INFORMANT Mrs. Mary E. Mades Address 3518 Nimitz Road Kensington, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO 4-4-X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute congestive heart failure DUE TO 4 hours (c) Hypertensive cardiovascular renal disease DUE TO 3 years					INTERVAL BETWEEN ONSET AND DEATH 20 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; hepatic cirrhosis; ethanolism					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/25 19 61 to 8/10 19 61 , that (I) (we) last saw the deceased alive on 7/25 19 61 , and that death occurred at 4:10 M, from the causes and on the date stated above.					
22a. SIGNATURE Joseph D. Connor, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Aug. 16, 1961	
22c. PHYSICIAN'S NAME (Type) Joseph D. Connor, M.D.		22d. ADDRESS 9420 Old Georgetown Road, Bethesda			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/19/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City, town, or county) Prince Georges County, Maryland		23e. LOCATION (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REGISTERED BY REGISTRAR AUG 21 61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hunk					

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

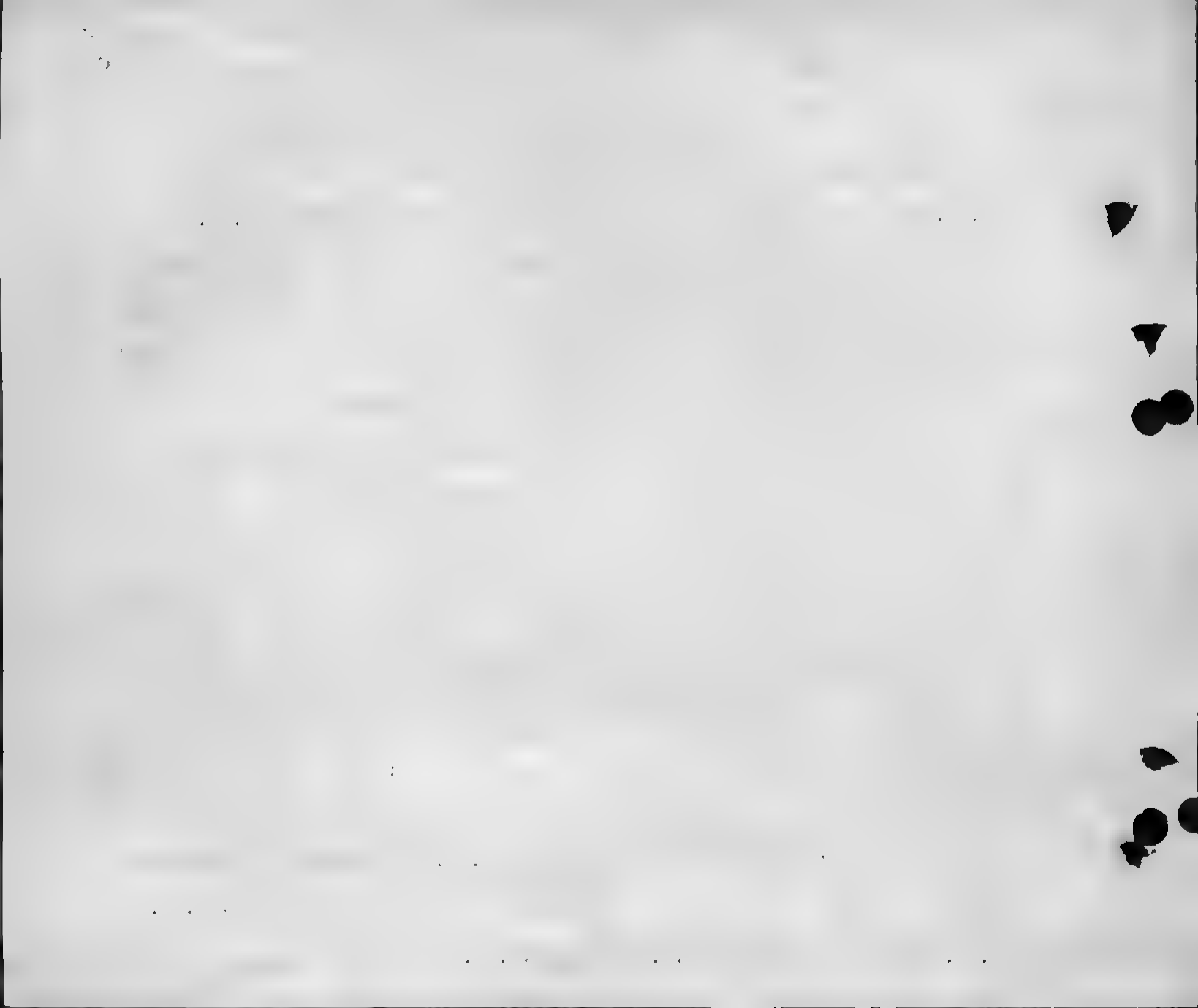
CERTIFICATE OF DEATH

0340

09331

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission, a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1819 Lamont Street, N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emilia Antonia</u> First Middle Last		4. DATE OF DEATH <u>August 21</u> <u>19 61</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-26-16</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE County & State, or foreign country <u>Argentina</u> 12. CITIZEN OF WHAT COUNTRY <u>Argentina</u>		13. FATHER'S NAME <u>Pedro Nataloni</u> 14. MOTHER'S MAIDEN NAME <u>Gilda Gervont</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>(H) Antonio Maresta</u> (If yes, give war or dates of service)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Metastases</u> <u>170X</u> DUE TO <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Washington</u> County <u>D.C.</u> (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 3</u> <u>19 61</u> to <u>August 21</u> <u>19 61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 21</u> <u>19 61</u> , and that death occurred at <u>8:20 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. F. Warrender</u> M.D.		22b. DATE SIGNED <u>August 21, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>W. F. WARRENDER, LT MC USN</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>22 August 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			
23d. LOCATION (City, town or county, State) <u>Washington, D. C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. HINES</u> ADDRESS <u>2901 14th St. N.W. Washington, D. C.</u>					
25a. REC'D BY REGISTRAR <u>Aug 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. They may be forwarded by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the d... be executed within 24 hours after death. Page 4
may be at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

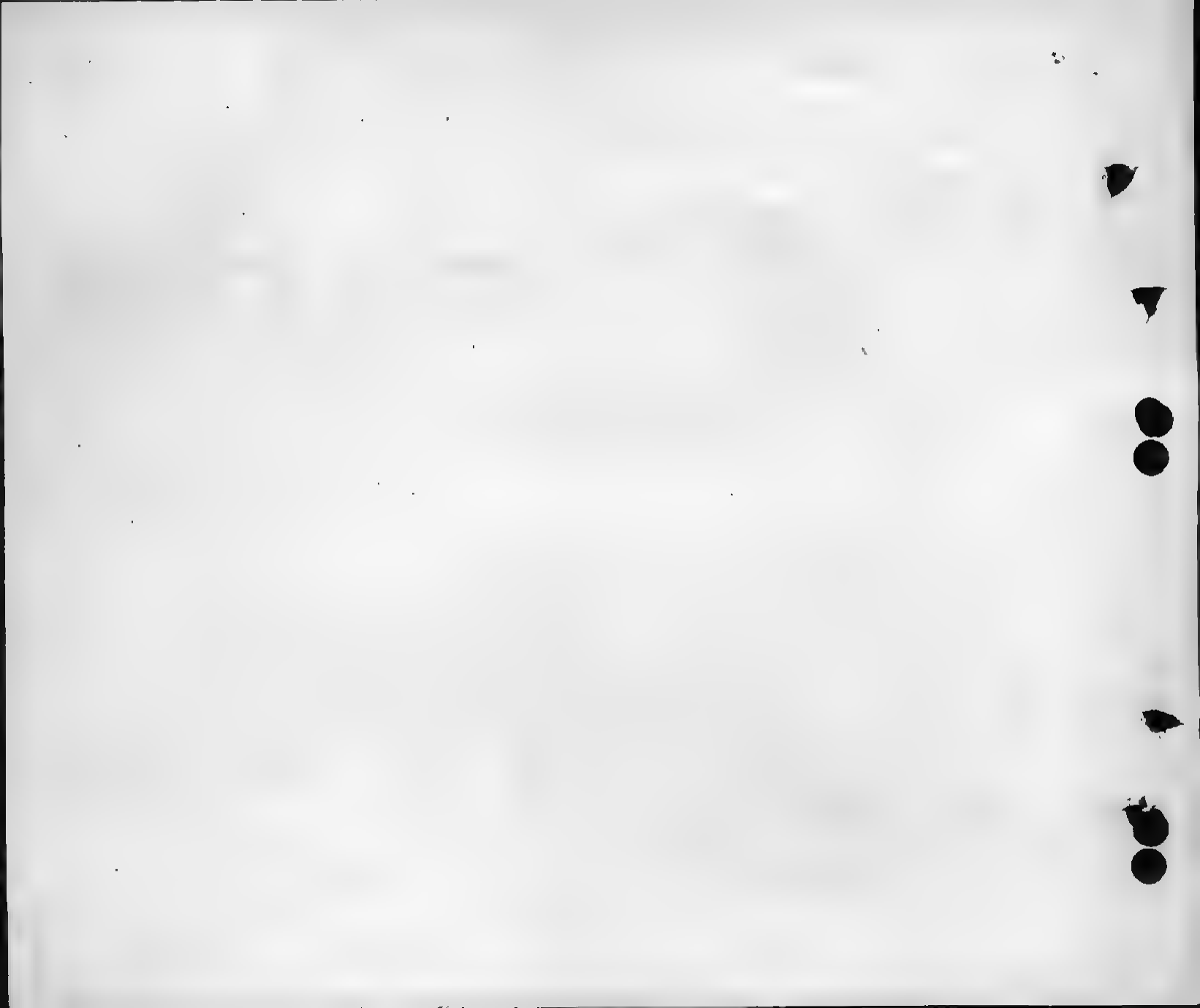
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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9341

09332

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5803 Melrose Drive</u>	
3. NAME DECEASED (Type or print) First <u>John</u> Middle <u>H</u> Last <u>MARTYN</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4 1887</u>
9. AGE (In years lost birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY YARD</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Martyn</u>		14. MOTHER'S MAIDEN NAME <u>Jane Minnis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Florence Martyn</u> wife - same as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>hypertension</u> DUE TO <u>hypertension</u> (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>61</u> , to <u>Aug.</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-10</u> , 19 <u>61</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip R. James</u>		22b. DATE SIGNED <u>8/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip R. James</u>		22d. ADDRESS <u>Washington Clinic, Wash. D. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/14/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. RECEIVED BY REGISTRAR <u>AUG 16 61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	





TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9343

CERTIFICATE OF DEATH

09334

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 29 days		2. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) a. STATE Virginia		b. COUNTY Colonial Beach		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 524 Lafayette St.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) U. S. Naval Hospital		First Earl		Middle Edward		Last McCartney		4. DATE OF DEATH Month August 11		Day 19		Year 61			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-12-89		9. AGE (in years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71		IF UNDER 24 HRS. Days 71			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy				11. BIRTHPLACE (County & State, or foreign country) Indiana				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank McCartney				14. MOTHER'S MAIDEN NAME Thurza M. Treadway				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II			
17. INFORMANT Hospital records				Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 13 19 61 to August 11 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 11 19 61 , and that death occurred at 2:50 PM from the causes and on the date stated above.												22a. SIGNATURE Paul G. Linaweaver		22b. DATE August 11, 1961	
22c. PHYSICIAN'S NAME (Type) PAUL G. Linaweaver, LCDR MC USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22f. DATE August 11, 1961			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF August 14, 1961				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Arlington Va			
24. FUNERAL DIRECTOR'S SIGNATURE Nash and Slaw Funeral Home, Colonial Beach, Va.				ADDRESS Colonial Beach, Va.				25a. SIGNED BY REGISTRAR Aug 16 61				25b. REGISTRAR'S SIGNATURE Arthur L. Hays			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

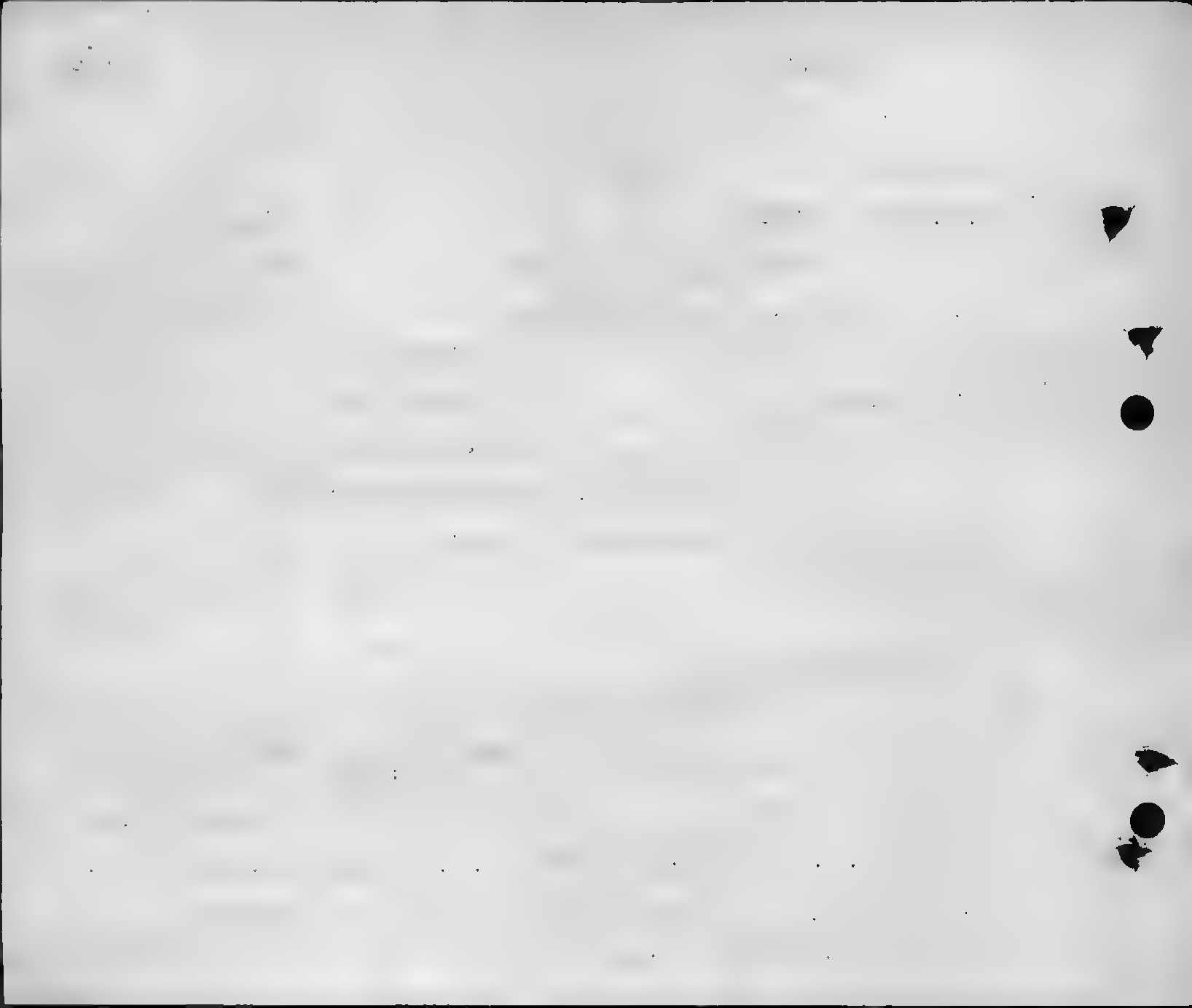
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9344 CERTIFICATE OF DEATH

09335

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY in b. <u>15 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Annapolis</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>207 Sycamore Court</u> d. STREET ADDRESS <u>207 Sycamore Court</u>							
3. NAME OF DECEASED (Type or print) <u>Cynthia Ann McCoy</u>		4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>6-25-61</u>							
9. AGE (In years last birthday) <u>158</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		11. PLACE OF BIRTH (County & State, or foreign country) <u>Maryland</u>							
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lonnie Joe McCoy</u>		14. MOTHER'S MAIDEN NAME <u>Patsy Ruth Oliver</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Lonnie Joe McCoy Same as # 2 above</u>		17. INFORMANT <u>Lonnie Joe McCoy Same as # 2 above</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <table border="0" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Total anomalous pulmonary venous drainage</u> </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Congenital heart disease</u> </td> </tr> <tr> <td colspan="2"> (c) <u></u> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Total anomalous pulmonary venous drainage</u>		Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Congenital heart disease</u>		(c) <u></u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Total anomalous pulmonary venous drainage</u>											
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Congenital heart disease</u>											
(c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.) <u></u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>							
20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 7, 1961</u> to <u>August 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 22, 1961</u> , and that death occurred <u>10:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>J. E. McClenathan</u>											
22b. DATE SIGNED <u>August 22, 1961</u>											
22c. PHYSICIAN'S NAME (Type) <u>J. E. McClenathan, CDR MC USN</u>											
22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial- shipment</u>		23b. DATE THEREOF <u>23 August 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beulah Church Cemetery</u>							
23d. LOCATION (City, town or county) <u>Albertville</u>		(State) <u>Ala.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>							
ADDRESS <u>1331 East Mont. Ave.</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

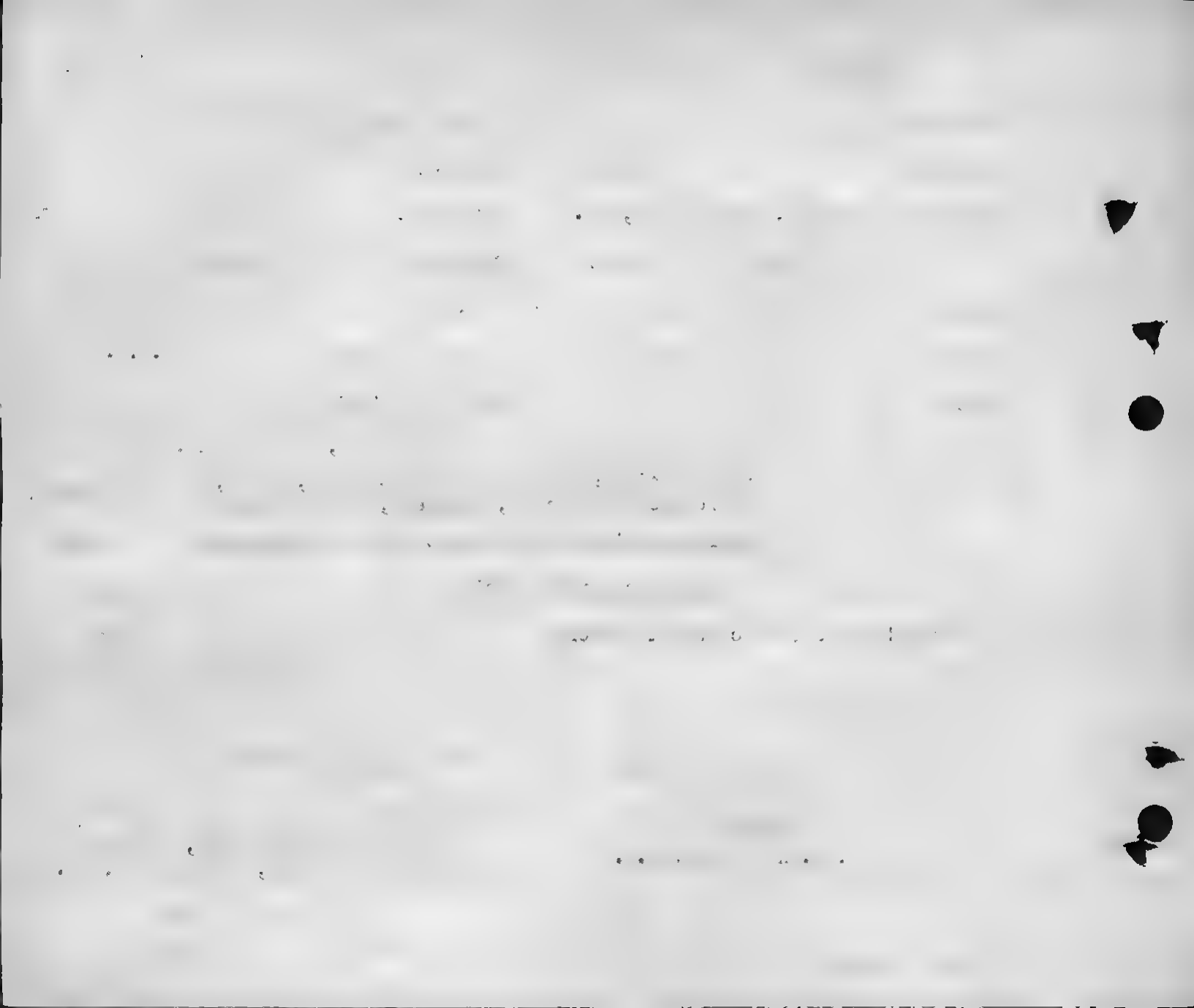
CERTIFICATE OF DEATH

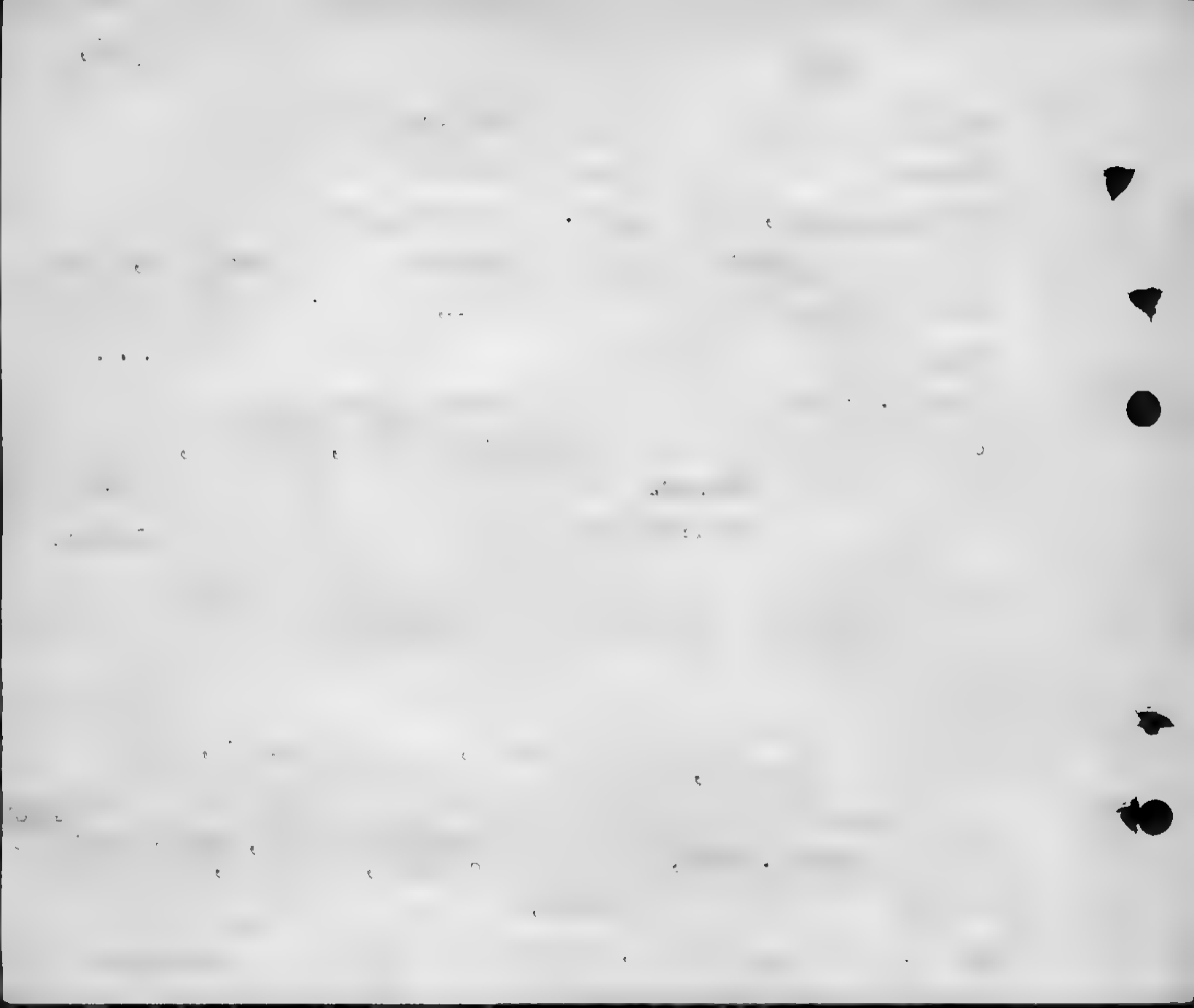
9345

09336

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE North Carolina b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Broadway d. STREET ADDRESS Route # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Luverta (None) McDougald		4. DATE OF DEATH Month August Day 7 Year 19 61	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1928	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY None	
10. BIRTHPLACE (County & State, or foreign country) North Carolina		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. FATHER'S NAME Adolph Amerson		13. MOTHER'S MAIDEN NAME Odessett Strange	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? No		15. SOCIAL SECURITY NO. Unascertainable	
16. INFORMANT The Medical Record		17. PLACE OF DEATH The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Choriocarcinoma with metastases to lung, liver, gastrointestinal tract, pancreas, skin & muscle (b) Gastrointestinal bleeding secondary to metastases (c) Bloody pericardial effusion Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. INTERVAL BETWEEN ONSET AND DEATH 9 months 6 months Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thyrotoxicosis by clinical history			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 14, 19 61 to August 7, 19 61 that (I) (we) last saw the deceased alive on August 7, 19 61, and that death occurred at 8:55 PM from the causes and on the date stated above.			
22a. SIGNATURE M. A. Kirschner		22b. DATE SIGNED 8/9/61	
22c. PHYSICIAN'S NAME (Type) M. A. KIRSCHNER, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-10-61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Broadway		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Stagier's Funeral Home		24b. ADDRESS 389-R. Ln	
25a. REC'D BY REGISTRAR AUG 14 '61		25b. REGISTRAR'S SIGNATURE Arthur C. Finner	

MEDICAL CERTIFICATION





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9347

05338

1. PLACE OF DEATH e. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3307 Oberon Street		d. STREET ADDRESS 3307 Oberon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jean Gould		4. DATE OF DEATH Month Day Year August 3 1961		5. SEX Female	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (Country & State, or foreign country) Maryland	
13. FATHER'S NAME John R. Gould		14. MOTHER'S MAIDEN NAME Amelia Mege		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Jean Sartwell-daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia (c) arteriosclerotic renal disease PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arterio sclerosis generalized		INTERVAL BETWEEN ONSET AND DEATH 3 weeks years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from March... , 1961, to August 3, 1961 , that (I) (we) last saw the deceased alive on August 1, 1961 , and that death occurred at 5:29 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Alfred S. Norton		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type or print) Alfred S. Norton, M.D.	
22d. ADDRESS 4711 Highland Ave., etc.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED Arthur S. Norton	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/61		23c. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cemetery	
23d. LOCATION (City, town or county) Baltimore, Maryland		23e. REC'D BY REGISTRAR AUG 8 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Norton	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24b. ADDRESS Bethesda, Maryland		24c. DATE AUG 8 '61	



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

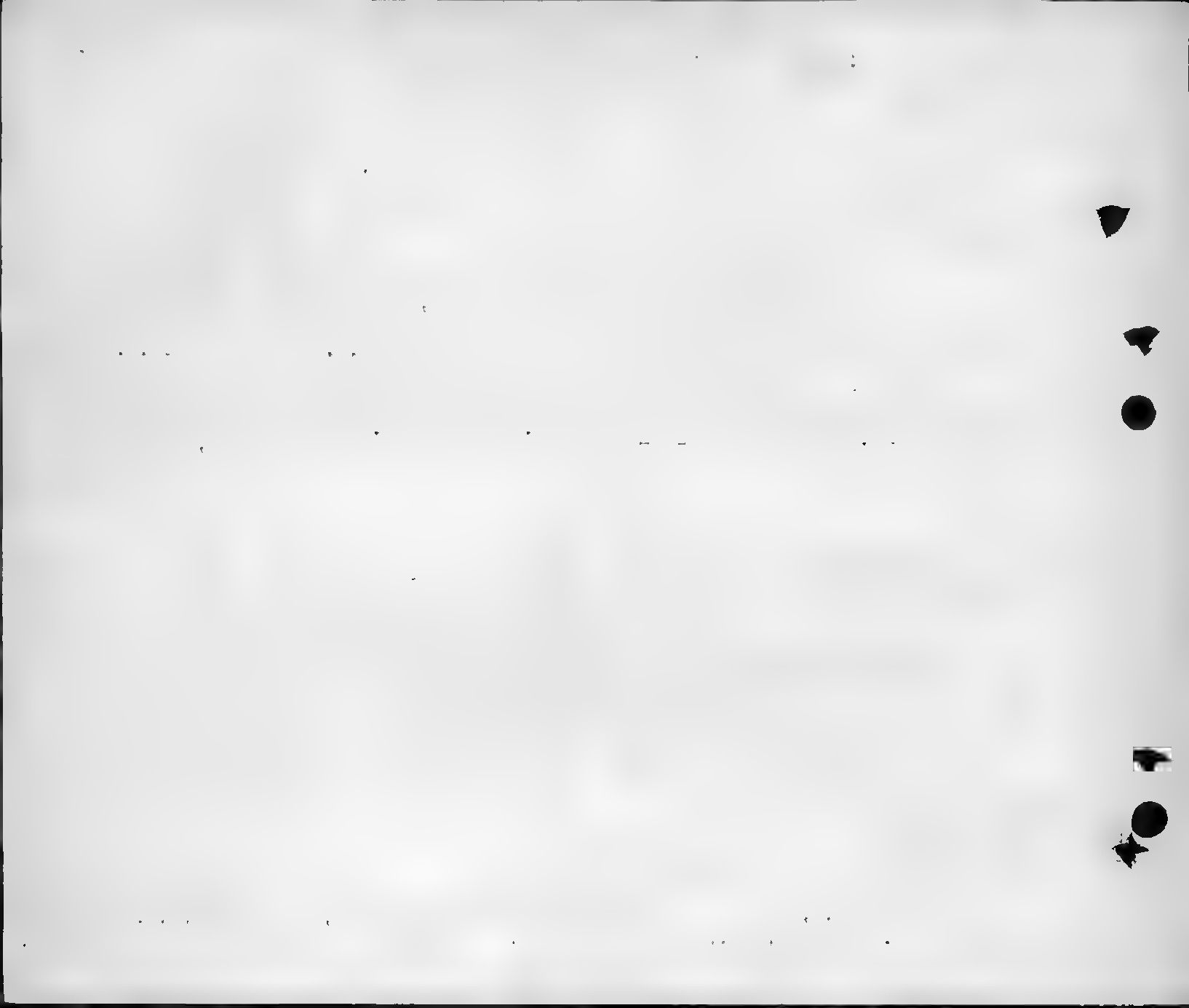
9348

CERTIFICATE OF DEATH

09339

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,			
c. LENGTH OF STAY IN 1b seven years				d. STREET ADDRESS 303 Ladson Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Ladson Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louis Edwin Metcalf				4. DATE OF DEATH August 8 1961			
5 SEX Male		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1905	
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafe/ateria Manager				10b. KIND OF BUSINESS OR INDUSTRY Food Services		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.							
13 FATHER'S NAME Frank John son				14. MOTHER'S MAIDEN NAME Virginia Clabaugh			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16 SOCIAL SECURITY NO 214-03-8683		17 INFORMANT Mrs. Elizabeth P. Metcalf Address 303 Ladson Road Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary Insufficiency DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH SUDDEN SEVERAL YES.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1959 to Aug 8, 1961 , that (I) (we) last saw the deceased alive on Aug 1, 1961 , and that death occurred at 11:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE M. F. OTTMAN				22b. DATE SIGNED 8/9/61			
22c. PHYSICIAN'S NAME (Type) M. F. OTTMAN				22d. ADDRESS 11800 Ga Ave			
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF AUG. 9, 1961		23c. NAME OF CEMETERY OR CREMATORY TO GEORGE WASHINGTON MEDICAL SCHOOL, WASHINGTON D.C.		23d. LOCATION (City, town, or county) (State) FOR MEDICAL RESEARCH.	
24 FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC., SILVER SPRING, MD.				25a. REC'D. BY REGISTRAR Aug 16 '61			
25b. REGISTRAR'S SIGNATURE Raymond H. Ziska							

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9349

09340

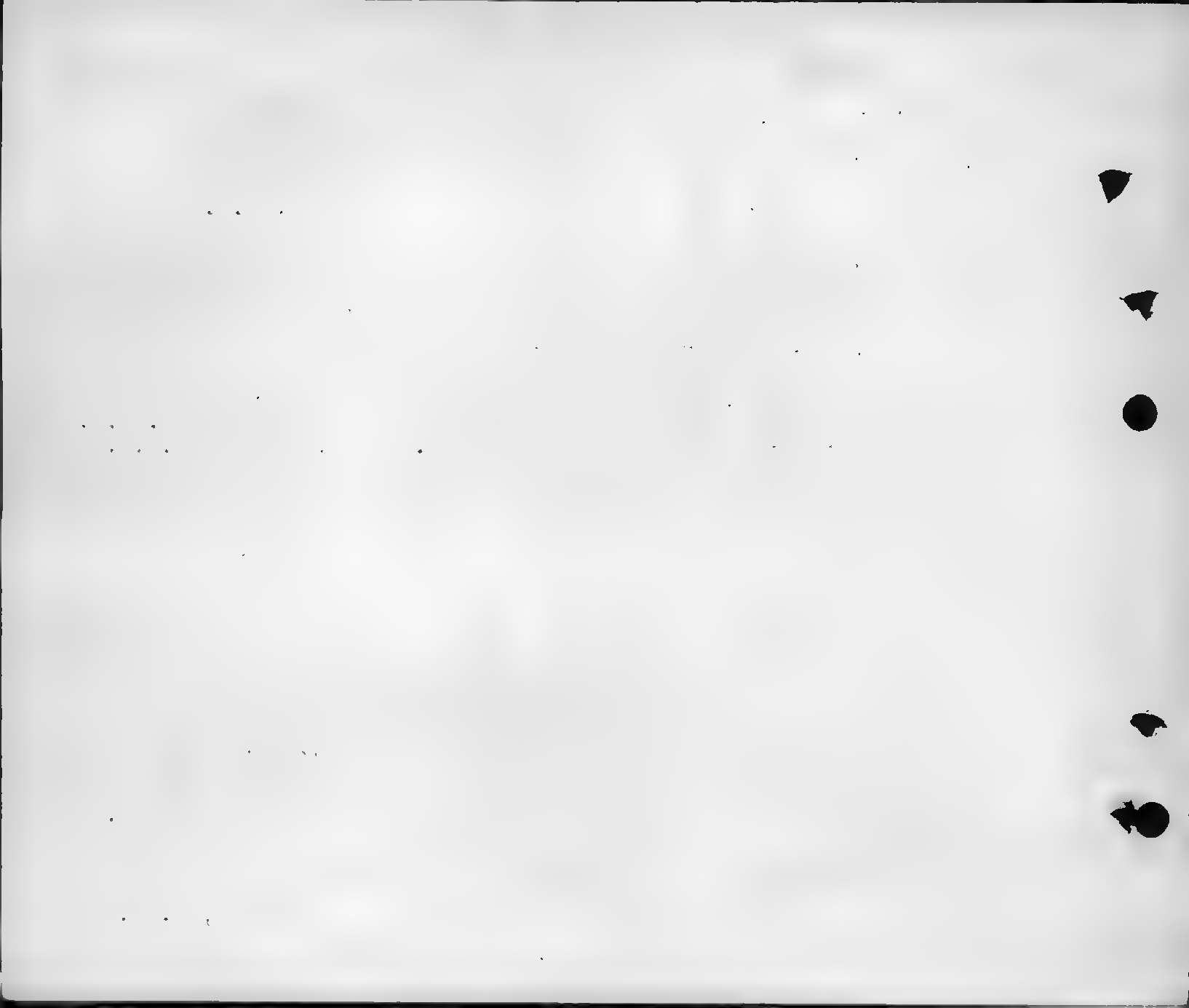
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE DC. b. COUNTY 4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Convalescent Home		d. STREET ADDRESS 1743 Irving Street, N.W.	
3. NAME OF DECEASED (Type or print) First Bertha Middle W. Last Meyer		4. DATE OF DEATH Month August Day 22 Year 1961	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1912
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 4 Days 15 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wilhelm Timm		14. MOTHER'S MAIDEN NAME Johanna Bach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT William J. Meyer, 3621 S St. N.W.		Address Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bowel Obstruction 450.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c) stating the <u>under</u> lying cause lost. (b) 450.0 DUE TO Generalized Arteriosclerosis (c) 450.0 DUE TO Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 40 days 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1959 to Aug 22, 1961 , that (I) (we) last saw the deceased alive on Aug 21, 1961 , and that death occurred at 1:30 PM , from the causes and on the date stated above			
22a. SIGNATURE James H. Whitehead M.D.		22b. DATE SIGNED 8-22-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-24-1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlin Smiley		25a. REC'D BY REGISTRAR Wash. D.C.	
25b. DATE AUG 25 '61		25c. REGISTRAR'S SIGNATURE Arthur S. Kline	

(M)

(I)

1

13P



9350

Clifford L. Krane

Same as #2 above

INTERVAL BETWEEN
ONSET AND DEATH

diffuse, metastatic neuroblastoma

neuroblastoma 1° in Rt. sciatic nerve 2 yars

2 par

May 30 1961 to August 7, 1961

MD

ATTENDING ☐
PHYS ☐

MED
DIRE

STAFF
PHYS

August 7, 1981

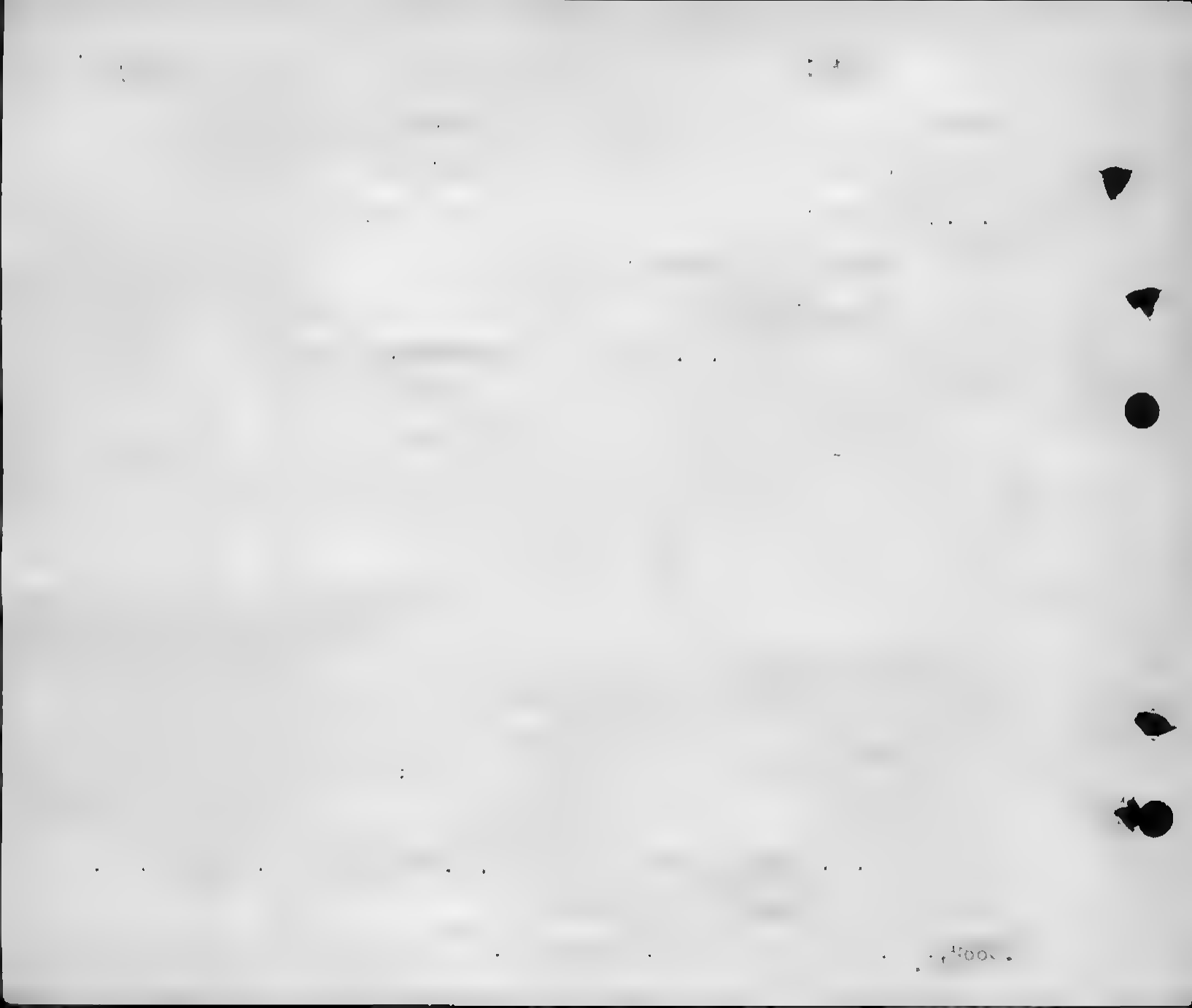
U. S. Naval Hospital, Bethesda, Md.

Wm. Cook, St. Paul and Preston St. Baltimore, Md.

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09342

9351

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN (b) 5 hours 55 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if different from residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 304 Southwest Drive

3. NAME OF DECEASED (Type or print) Sadie
First Middle Last
Lelia Milam

4. DATE OF DEATH August 28, 1961
Month Day Year

5. SEX Female
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH May 29, 1881
Month Day Year

9. AGE (In years last birthday) 80
If UNDER 1 YEAR: Months Days
If UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Mississippi
11. BIRTHPLACE (County & State, or foreign country) U. S. A.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Archer Tatum
14. MOTHER'S MAIDEN NAME Mollie Tribble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT Washington Sanitarium Hospital Records
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho pneumonia
(b) Cerebral thrombosis with left hemiplegia
(c) 4 wks
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
INTERVAL BETWEEN ONSET AND DEATH
2 days

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1961 to August 28, 1961, that (I) (we) last saw the deceased alive on August 28, 1961, and that death occurred at 10:28 P.M. from the causes and on the date stated above.

22a. SIGNATURE Bennet A. Porter, Jr.
22b. DATE SIGNED Aug. 28, 1961
22c. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.
22d. ADDRESS 9301 Coleridge Rd., Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP R.R.
23b. DATE THEREOF 8-29-61
23c. NAME OF CEMETERY OR CREMATORY PEA RIDGE CEMETERY GRENADA MISS
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE W. H. Chambers, 140 Chapin St., N. W.
ADDRESS Nash. 9-12
25a. REC'D BY REGISTRAR AUG 30 '61
25b. REGISTRAR'S SIGNATURE Arthur L. Hines

(X)

✓

37. 100%

100% - 100% = 0%

0%

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

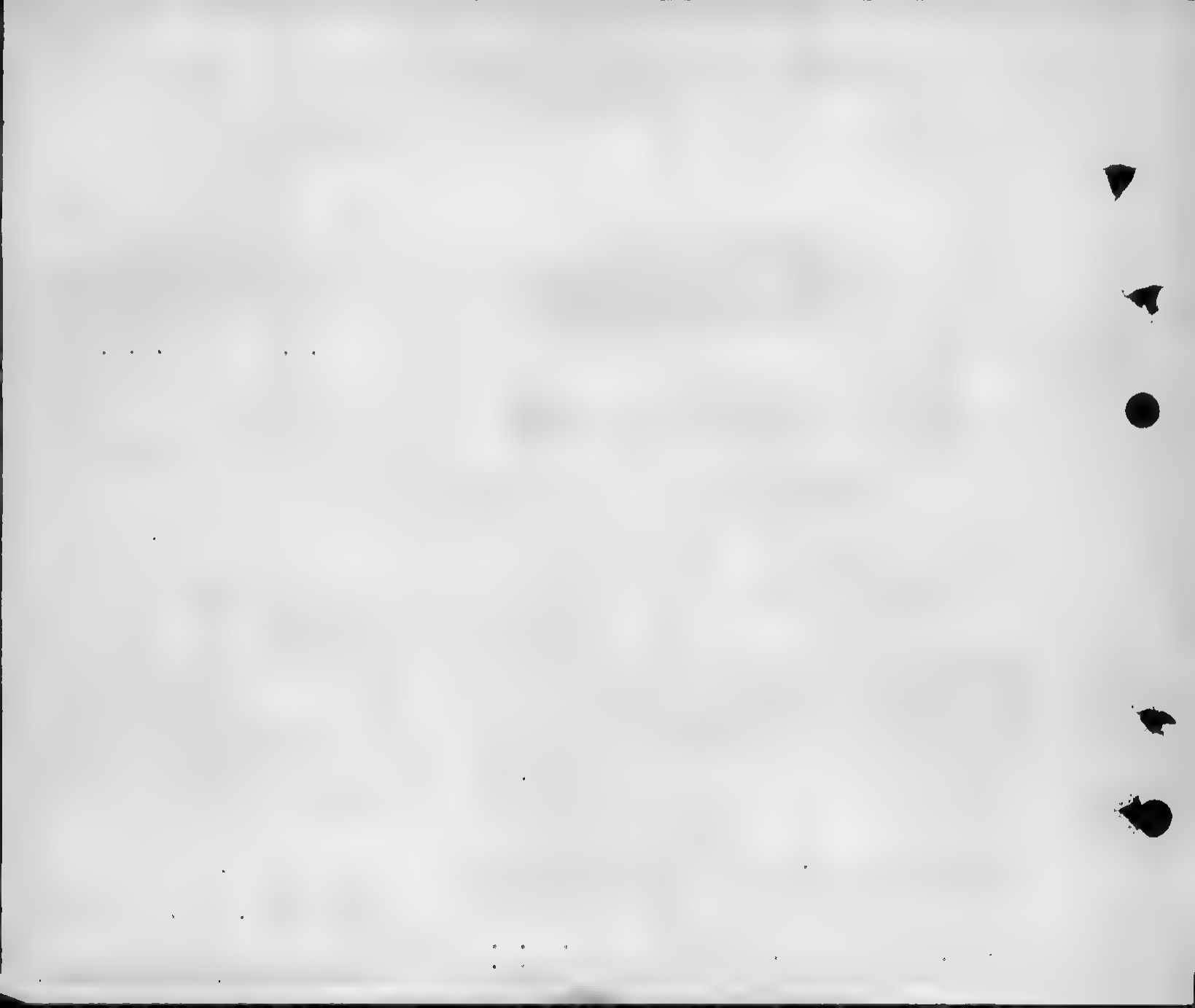
09343

9352

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4503 Renn Street		d. STREET ADDRESS 4503 Renn Street	
3. NAME OF DECEASED (Type or print) First Ethel Middle May Last Miller		4. DATE OF DEATH Month August Day 19 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/89
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Schlosser		14. MOTHER'S MAIDEN NAME Georgiana Avery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Norman Harry Miller		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Primary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9 weeks (c) years		INTERVAL BETWEEN ONSET AND DEATH 9 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20, 1961 to August 19, 1961 , that I last saw the deceased alive on Aug 19, 1961 , and that death occurred at 8 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave, Silver Spring, Md DATE SIGNED 8/19/61 ACTUAL SIGNATURE John J. Avery PHYSICIAN'S NAME (Type) John J. Avery			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/23/61	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE AUG 22 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9353

09344

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY (in days) <u>2 yrs. 6 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>5500 Flower Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Janet</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-28-75</u> 9. AGE (in years last birthday) <u>86</u> yrs.		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1961</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 11b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel Miller</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Evelyn</u> Address <u>Washington San & Hosp Records</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO (If assigned, give number of card) <u>None</u>		17. INFORMATION <u>Washington San & Hosp Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis</u> DUE TO (b) <u>auricular Fibrillation</u> DUE TO (c) <u>Acute Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>Aug 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 9, 1961</u> , and that death occurred <u>2:40 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Robert A. Hare</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7600 Carroll Ave., T.P., Md.</u>		22b. DATE SIGNED <u>Aug 10, 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>		23a. BURIAL-CREMATATION, REMOVAL (Specify) <u>Cremation</u>					
23b. DATE THEREOF <u>Aug 11-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>		23d. LOCATION (City, town or county) <u>Adamsburg, Pa.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hare</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hare</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>			
25c. ADDRESS <u>254 Carroll St NW</u>		DATE <u>AUG 14 '61</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



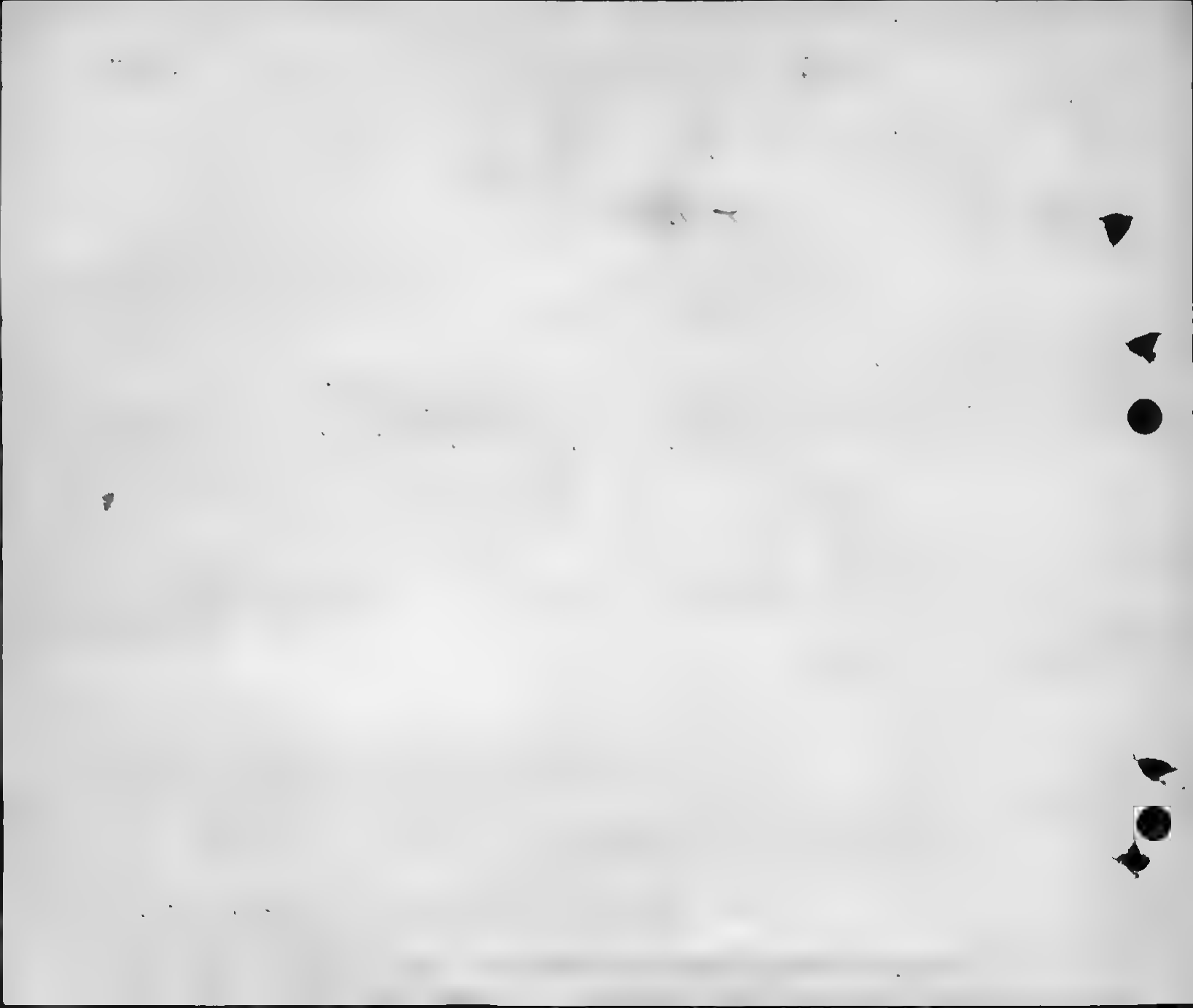
TO HOSPITAL OR DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

A. Brochats

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
9354																							
9345																							
CERTIFICATE OF DEATH																							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6105 Gloster Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wash. 16, DC - Bethesda MD</u> d. STREET ADDRESS <u>6105 Gloster Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>BERNARD</u> First <u>J</u> Middle <u>MONTY</u> Last				4. DATE OF DEATH <u>Aug 12 1961</u> Month <u>Aug</u> Day <u>12</u> Year <u>1961</u>				5. AGE (In years, last birthday) <u>43</u> yrs. <u>6</u> months <u>12</u> days IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>0</u> Mins. <u>0</u>															
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>29 Feb 1888</u> 9. AGE (In years, last birthday) <u>43</u> yrs. <u>6</u> months <u>12</u> days IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>0</u> Mins. <u>0</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weaver</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>															
13. FATHER'S NAME <u>Louis Monty</u>				14. MOTHER'S MAIDEN NAME <u>Josephine</u>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>029-01-222</u>				16. SOCIAL SECURITY NO. <u>029-01-222</u> 17. INFORMANT <u>Mr Robert J Monty</u> Address <u>6105 Gloster Rd Bethesda Md.</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO <u>myocarditis, chronic</u> Conditions, if any, which gave rise to immediate cause (b) <u>Emphysema, genl severe</u> DUE TO <u>1 year.</u> cause last (c) <u>1 yr.</u>												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) 20f. (City or town) (County) (State)																							
21. I certify that (I) (this hospital) attended the deceased from <u>not</u> <u>4 Aug 1961</u> to <u>Aug 12 1961</u> , that (I) (we) last saw the deceased alive on <u>4 Aug 1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.																							
22a. SIGNATURE <u>Herbert Martyn Jr</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12 Aug 61</u>																							
22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u> 22d. ADDRESS <u>5029 Bethesda Ave Bethesda Md.</u>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/16/61</u> 23b. DATE THEREOF <u>Bethany Cem. Monson, Mass.</u> 23c. NAME OF CEMETERY OR CREMATORY <u>510 W. 1st St</u> 23d. LOCATION (City, town or county) (State)																							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chevy Chase Funeral Home, Wash DC</u> ADDRESS <u>510 W. 1st St</u> 25. REC'D BY REGISTRAR <u>AUG 16 61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>																							



6 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
Montgomery Takoma Park 13 minutes Washington Sanitarium + Hosp 10115 Tenbrook Dr				Maryland Silver Spring			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
Jerome X NMN Morris				8 24 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH	
m		w		X NEVER MARRIED		7-31-08	
				WIDOWED		53 yrs.	
				DIVORCED			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Attorney				N.Y.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Max Morris				Nettie Neuman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
NO				old Hosp. Record.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				19. WAS AUTOPSY PERFORMED?			
PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 465X				PULMONARY EMBOLISM, MASSIVE SUDDEN			
Conditions, if any, which gave rise to immediate cause (b)							
IMMEDIATE CAUSE (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY				20d. INJURY OCCURRED			
Month, Day, Year				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
Hour a.m. p.m.				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
19				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
BURIAL				AUG. 25, 1961			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
CEDAR PARK CEMETERY				EMERSON N.J.			
23. FUNERAL DIRECTOR				24a. REC'D BY REG STRAR			
B Dingus, & Son				DATE AUG 28 '61			
ADDRESS				24b. REGISTRAR'S SIGNATURE			
3501-145th HW.				Arthur S. Hines			



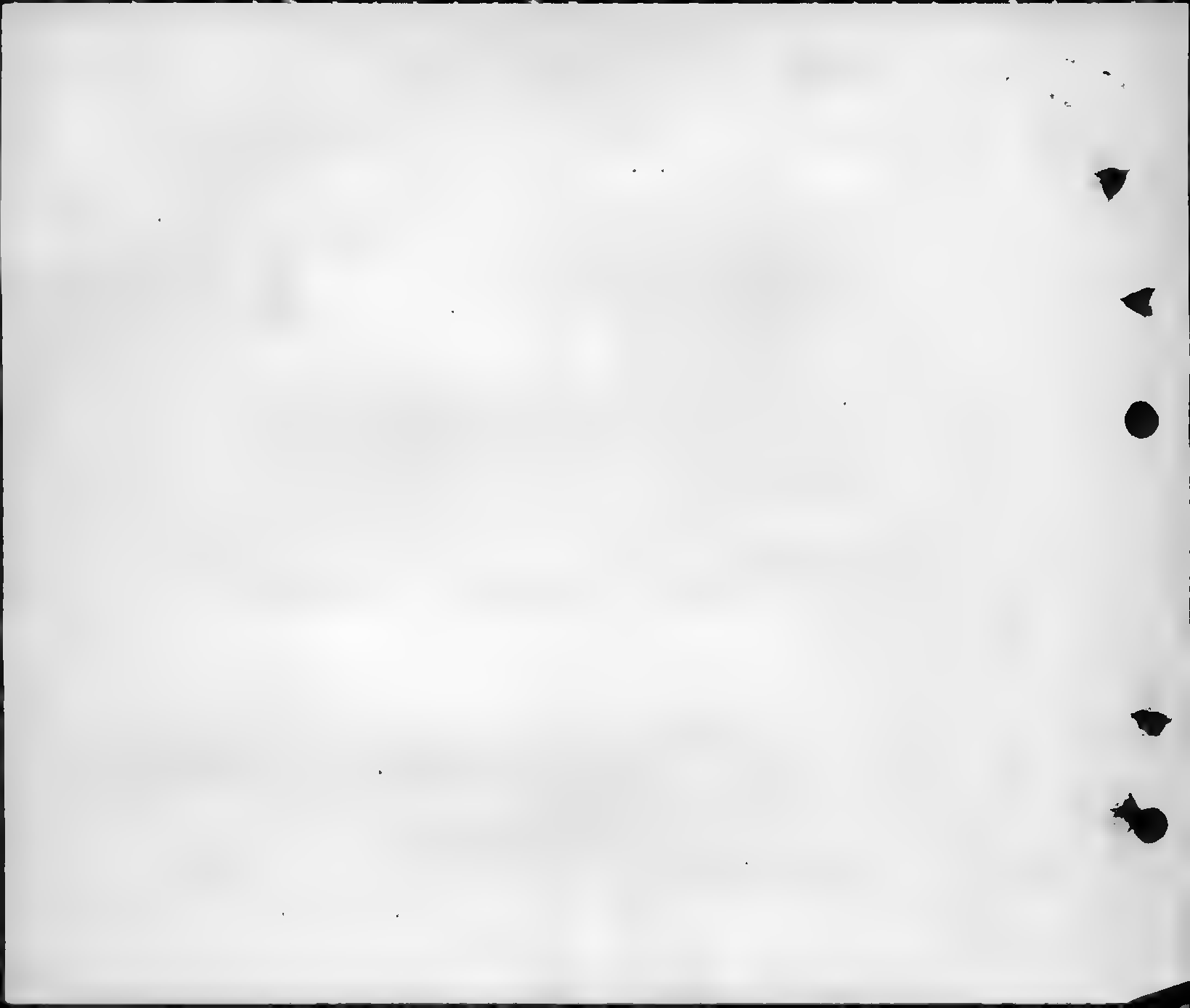
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital for attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
6
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9356
CERTIFICATE OF DEATH

09347

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>4507 Muncaster Mill Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Richard</u> Last <u>Mulligan</u>		4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 1, 1927</u>
9 AGE (In years last birthday) <u>33</u> yrs		IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u> Hours <u></u> Min <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glazier</u>		10b KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry E. Mulligan</u>		14 MOTHER'S MAIDEN NAME <u>Nora Earp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17 INFORMANT <u>Hospital Records</u>		Address <u></u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic coronary atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>4 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u>a</u> m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 13, 1957</u> to <u>Aug 22, 1961</u> that (I) (we) last saw the deceased alive on <u>Aug 1, 1961</u> and that death occurred at <u>7:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard A. Yates MD</u>		22b. DATE SIGNED <u>8-23-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Yates, MD</u>		22d. ADDRESS <u>Old Baltimore Road, Olney, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Church Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Neelsville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u></u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	
DATE <u>AUG 28 '61</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9357

CERTIFICATE OF DEATH

09348

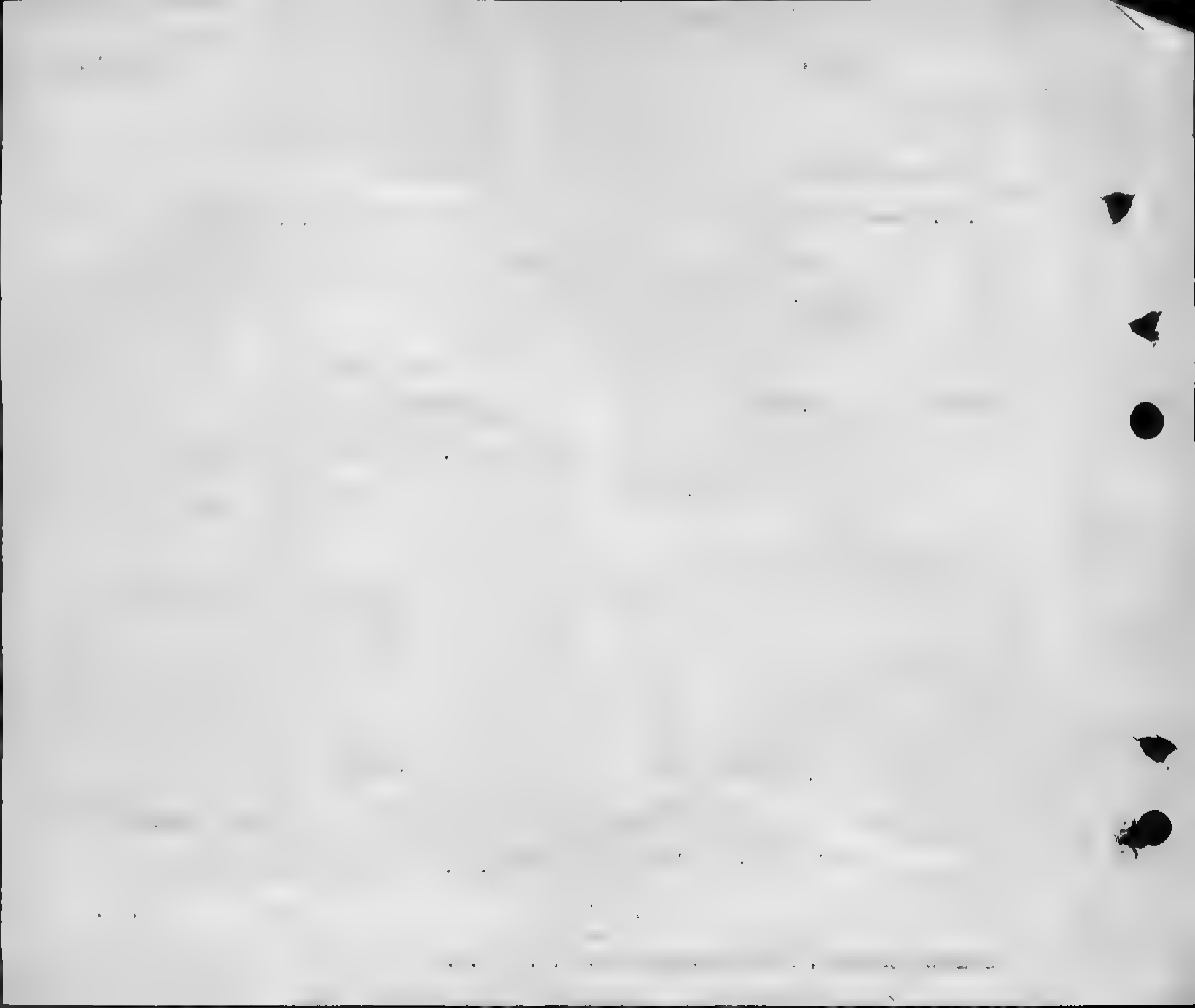
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3402 13th Place, S.E. Apt 101</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy NAULT</u> First Middle Last 5 SEX <u>Male</u> 6 COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8-24-61</u> widowed <input type="checkbox"/> divorced <input type="checkbox"/>		4. DATE OF DEATH <u>August 27 19 61</u> Month Day Year 9 AGE (In years less birthday) <u>3</u> IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Arthur Nault</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>No</u> 17. INFORMANT <u>George A. Nault Same as #2 above</u> Address <u>Margaret Ann Howard</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Howard</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>754.5</u> DUE TO <u>Heart Disease, congenital, Cyanotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>August 24, 19 61</u> Hour a.m. <u>3:15 AM</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hospital, Bethesda, Md.</u> 20f. (City or town) <u>Washington</u> (County) <u>D. C.</u> (State) <u>D. C.</u>		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 24, 19 61</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive <u>August 27, 19 61</u> and that death occurred at <u>3:15 AM</u> from the causes and on the date stated above 22a. SIGNATURE <u>Lawrence G. Thorne</u> M.D. 22b. DATE SIGNED <u>August 28, 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>Lawrence G. Thorne, LT MC USN</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>30 August 1961</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Brother</u> ADDRESS <u>Washington, D.C.</u> <u>Simmons Brother, 1661 Good Hope Rd. S.E.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> 23d. LOCATION (City, town or county) <u>Washington</u> (State) <u>D. C.</u> 25a. REC'D BY REGISTRAR <u>August 30 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in duplicate, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

-2651224XV



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

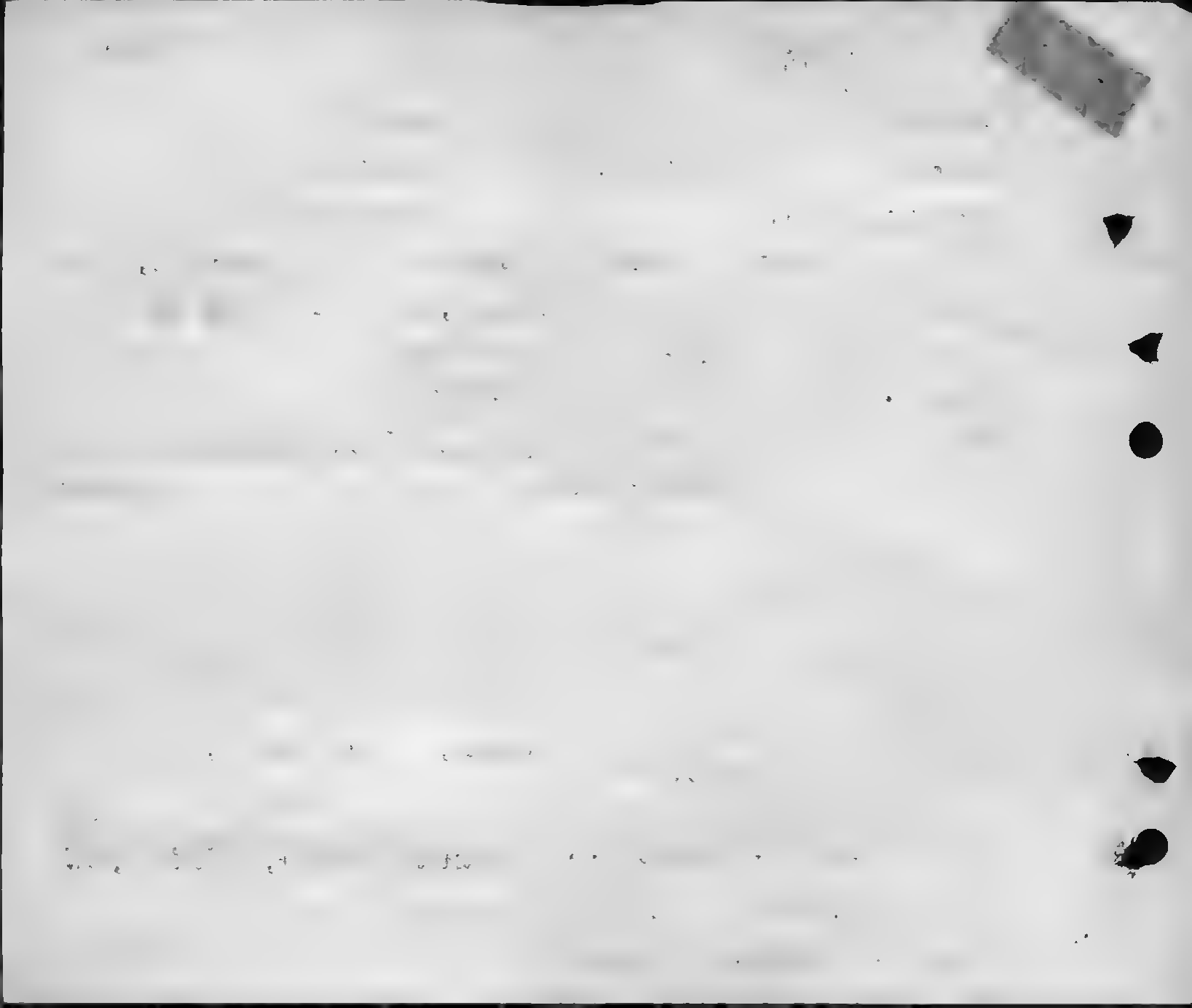
9358

CERTIFICATE OF DEATH

09349

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY Apalachin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Apalachin d. STREET ADDRESS 19 Meadow Lane	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 28 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center			
3. NAME OF DECEASED (Type or print) NANCY MARIE NINNIE		4. DATE OF DEATH Month August Day 9 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8, 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Child)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZENSHIP OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene R. Ninnie		14. MOTHER'S MAIDEN NAME Elizabeth Lang	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Tetralogy of Fallot IMMEDIATE CAUSE (a) 7-4-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGENITAL	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19	
20f. (City or town) 19		20g. (County) 19	
20h. (State) 19		21. I certify that (I) (this hospital) attended the deceased from July 12, 1961 to August 9, 1961 that (I) (we) last saw the deceased alive on August 9, 1961 , and that death occurred at 1:47 p.m. the causes and on the date stated above.	
22a. SIGNATURE RICHARD P. ANDERSON, M.D.		22b. DATE SIGNED 8-10-61	
22c. PHYSICIAN'S NAME (Type) RICHARD P. ANDERSON, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans.		23b. DATE THEREOF 8/10/61	
23c. NAME OF CEMETERY OR CREMATORY St. Joachims Cemetery		23d. LOCATION (City, town or county) (State) Beacon, New York	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR AUG 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSTS OR ATTENDING PHYSICIAN: The law requires the death certificate be executed within 24 hours after death. The law requires the attending physician to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit, and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9359 CERTIFICATE OF DEATH 09350

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Saratoga</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>140115</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Saint Hosp.</u>		d. STREET ADDRESS <u>197-13 89th Rd</u>	
3. NAME OF DECEASED (Type or print) <u>MARIE</u>		4. DATE OF DEATH <u>8-6</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-88</u>	
9. AGE (In years, last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S. W.F.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>FRED HESS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH WELZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MRS. Emma M. Montay</u>	
17. INFORMANT <u>MRS. Emma M. Montay</u>		Address <u>197-13 89th Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion + Ventricular Fibrillation</u>			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u>Coronary Sclerosis</u>			
(c) <u>generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Coronary NOTIFIED AND APPROVED</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7:45 P.M. Aug 6, 1961</u> to <u>10:45 P.M. Aug 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 6, 1961</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Marvin L. Kolkin</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN L. KOLKIN</u>		22d. ADDRESS <u>1015 SPRING STREET, S.S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MIDDLE VILLAGE LONG ISLAND, N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond R. Ziska</u> ADDRESS <u>Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>		25c. DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09351

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

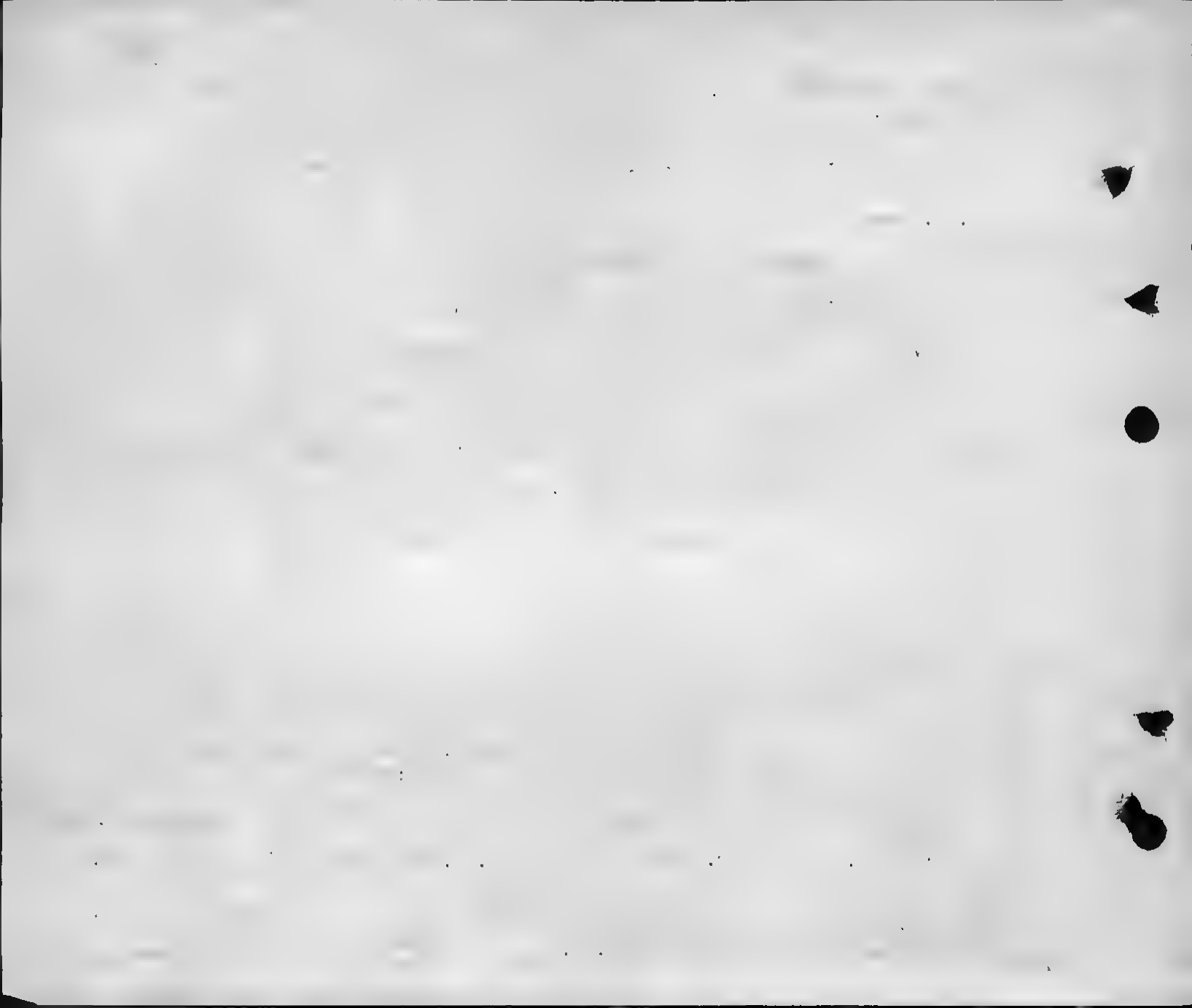
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5620 Woodway Drive</u>				d. STREET ADDRESS <u>5620 Woodway Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Lois</u> Middle <u>Nelson</u> Last <u>Noble</u>				4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/2/13</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jay W. Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Lena McIntire</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Husband - W. B. Noble</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.1 Fat embolism</u> DUE TO (b) <u>hepatic fatty metamorphosis</u> DUE TO (c) <u>Cronic alcoholism</u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>8-15-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State) <u> </u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u>AUG 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	





Arthur J. Knapp

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9363

09354

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>25 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Great Falls</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Great Falls</u> d. STREET ADDRESS <u>RFD # 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willard Moore Oliver</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1961</u> 8. DATE OF BIRTH <u>3-21-97</u> 9. AGE (in years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>		13. FATHER'S NAME <u>Benjamin Oliver</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>(S) Charles Oliver 4215 S. Four Mile Dr. Arlington</u> 17. INFORMANT <u>Arlington</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> (b) <u>metastasis</u> (c) <u>Bronchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <u> </u> (this hospital) attended the deceased from <u>July 27</u> <u>1961</u> to <u>August 21</u> <u>1961</u> that <u> </u> (we) last saw the deceased alive on <u>August 21</u> <u>1961</u> , and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>D. L. Kettering</u> 22c. PHYSICIAN'S NAME (Type) <u>D. L. KETTERING, LT MC USN</u> 22b. DATE SIGNED <u>22 August 1961</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>25 August 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arnon Cemetery</u> 23d. LOCATION (City, town or county) <u>Great Falls</u> (State) <u>Va.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Kettering</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u> DATE <u>AUG 24 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be retained by the hospital or attending physician. Page 1 of 2 should be retained by the hospital or attending physician and completely filled out by the funeral director. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9364

99355

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>10 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5517 Hoover Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5517 Hoover Street</u>	
3. NAME OF DECEASED (Type or print) <u>James E. O'Neill</u>		4. DATE OF DEATH <u>August 4 1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-15-1884</u> 9. AGE (In years IF UNDER 1 YEAR last birthday) <u>77</u> yrs. Months <u>4</u> Days <u>19</u> Hours <u>61</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Mail Room</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Trinity College</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward J. O'Neill</u> 14. MOTHER'S MAIDEN NAME <u>Bridget Galvin</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give service record) no
16. SOCIAL SECURITY NO. 579-10-5946
17. INFORMANT Mary M. Isilton
 Address 5517 Hoover St. Bethesda, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>arterio-sclerotic heart</u> DUE TO (c) <u>generalized arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u> <u>?</u> <u>?</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Paralysis of the muscles used in swallowing

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
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21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1961 to Aug. 4, 1961, that (I) (we) last saw the deceased alive on Aug. 2, 1961, and that death occurred at 2 P.M. from the causes and on the date stated above.

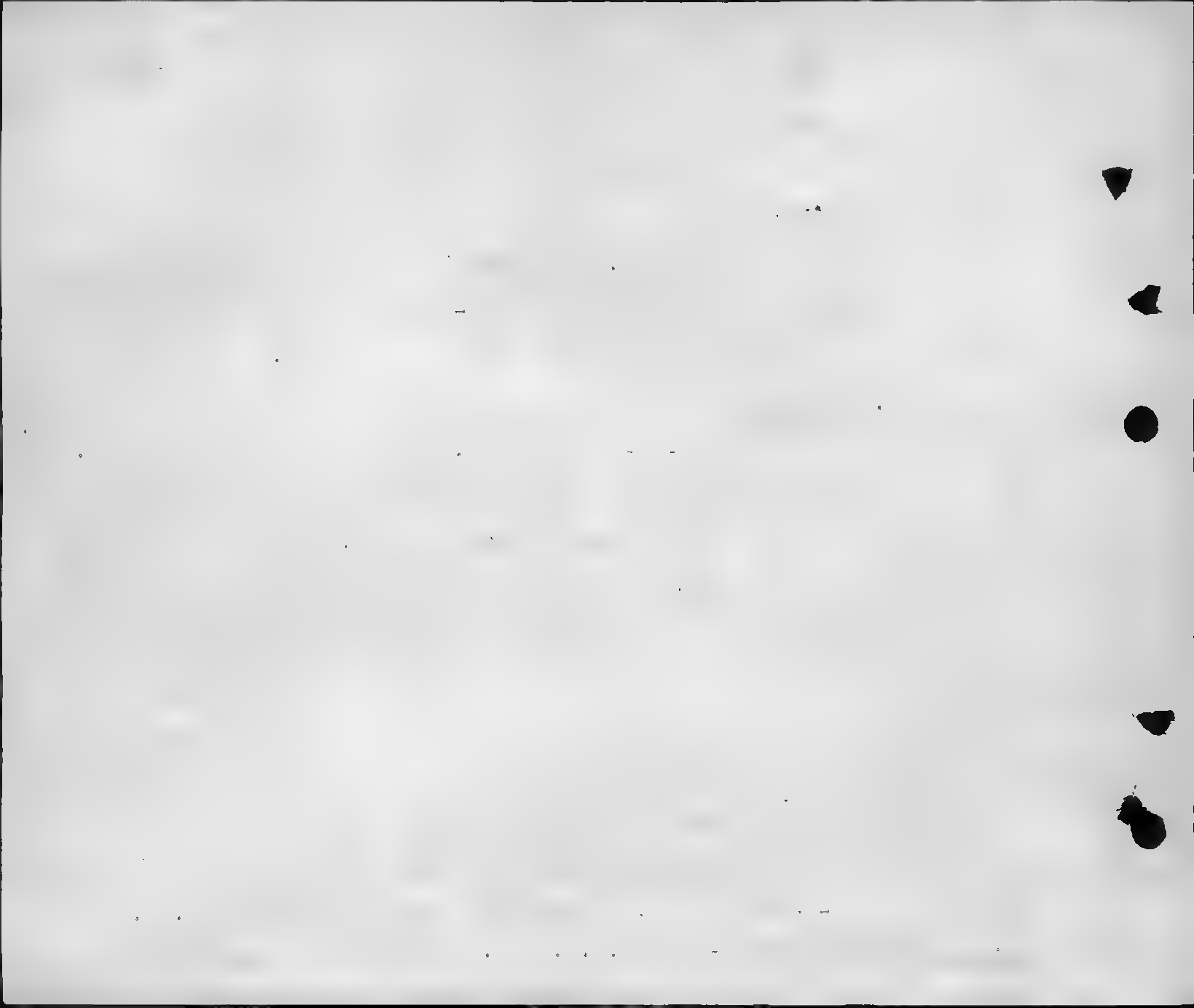
22a. SIGNATURE <u>Walter H. Angevine, M.D.</u>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS <u>6300-13th ST, N.W., WASH., D.C.</u>	22b. DATE SIGNED <u>Aug. 4, 1961</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-7-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Olivet Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>
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24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>	25a. REC'D BY REGISTRAR <u>DATE AUG 8 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be retained by the hospital or attending physician. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



1
FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09356

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Gaithersburg**
c. LENGTH OF STAY N 1b **DOA**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **B & O R R tracks.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Montg.**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Gaithersburg**
d. STREET ADDRESS **Stewardtown Rd.**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **Buell Owens**
4. DATE OF DEATH **8/26/61**
5. SEX **male** 6. COLOR OR RACE **Negro** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **8/17/45**
9. AGE (In years last birthday) **36** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **laborer** 10b. KIND OF BUSINESS OR INDUSTRY **Police record** 11. BIRTHPLACE (State or foreign country) **Md.** 12. CITIZEN OF WHAT COUNTRY? **USA**

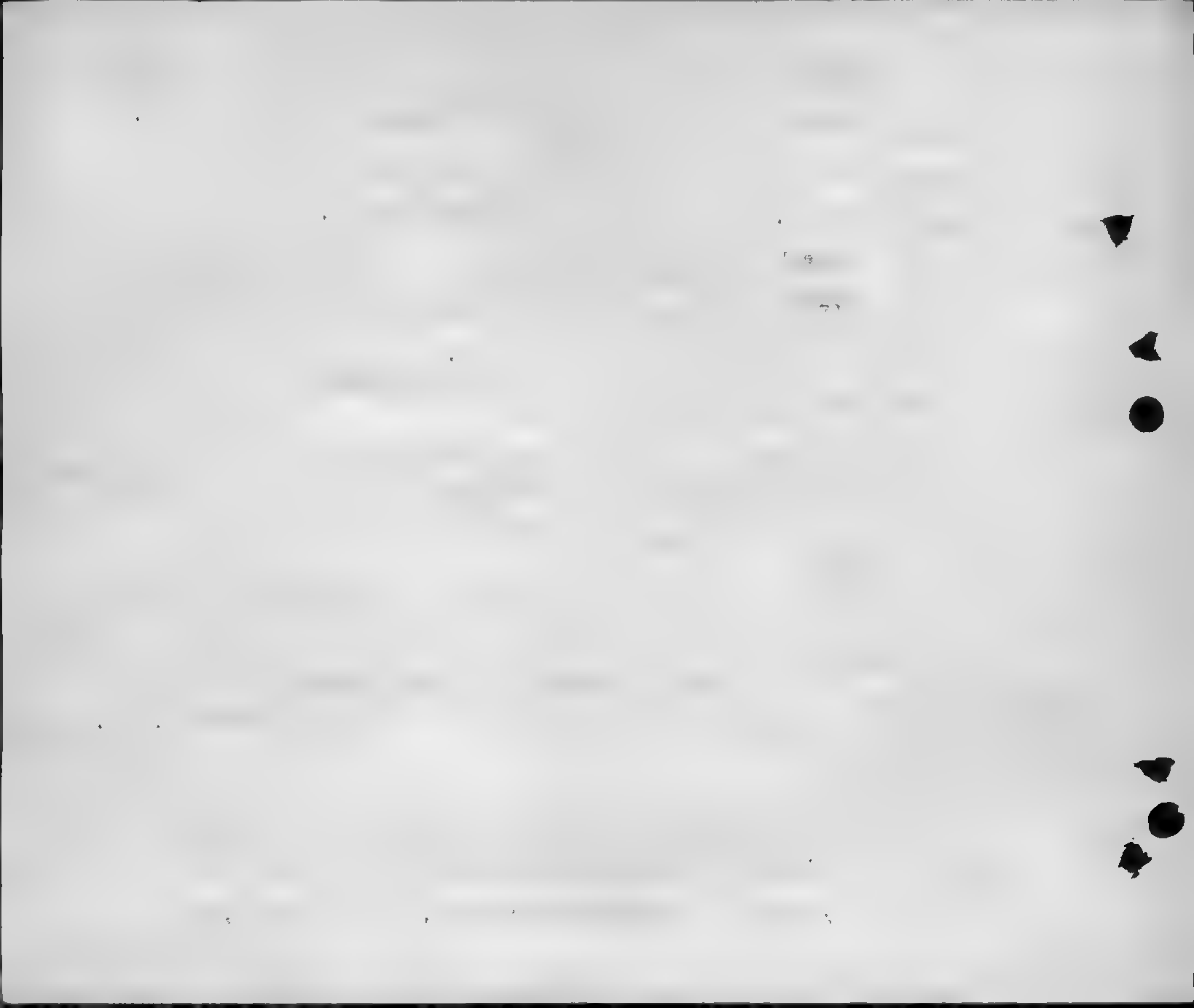
13. FATHER'S NAME **George Owens** 14. MOTHER'S MAIDEN NAME **Augusta Barnes**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address **Police record**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Multiple injuries, extreme**
DUE TO (b) **Head partially decapitated**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Struck by passenger train while walking on RR tract**
20c. TIME OF INJURY Month, Day, Year **11:25 a.m. 8/26/61** 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) **B & O R R** 20f. (City or town) **Gaithersburg** (County) **Montg.** (State) **Md.**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **8/27/61**
ACTUAL SIGNATURE **Frank J. Broschart** M.D. ADDRESS (Street, city, town, or county)
EXAMINER'S NAME (Type) **Frank J. Broschart**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **8/30/61** 22c. NAME OF CEMETERY OR CREMATORY **Arlington National Cem.** 22d. LOCATION (City, town, or country) (State) **Arlington, Va.**
23. FUNERAL DIRECTOR **Robert L. Snowden** ADDRESS **Rockville, Md.** 24a. REC'D BY REGISTRAR **SEP 1 '61** 24b. REGISTRAR'S SIGNATURE **Arthur S. Harris**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four PMOs. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9367

09358

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Hopewell</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hopewell</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Convalescent Home.</u>				d. STREET ADDRESS <u>67 X</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie French Palmer</u>				4. DATE OF DEATH Month Day Year <u>Aug 24 1961</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 13 1876</u>	9. AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harvey Roop.</u>				14 MOTHER'S MARDEN NAME <u>Agnes Hall</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>no</u>		17 INFORMANT Address <u>Mrs. Edith Popehoe, 9502 Thorn Hill Rd., Silver Sp., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)							<u>7 months</u> <u>Several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)		
21 I certify that (I) (this hospital) attended the deceased from <u>May 7, 1961</u> , to <u>August 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 18, 1961</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							22b DATE SIGNED <u>Aug. 24, 1961</u>
22a SIGNATURE <u>Bennet A. Porter, Jr.</u>		M. D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d ADDRESS <u>9301 Coleridge Rd., Silver Spring Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>8/25/61</u>	23c NAME OF CEMETERY OR CREMATORY <u>Highlands Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Hopewell, N.J.</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Hines Co.</u>		ADDRESS <u>2901-14th ST. NW. N.C.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>		25b REGISTRAR'S SIGNATURE <u>W. H. Hines</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 of this certificate may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit.

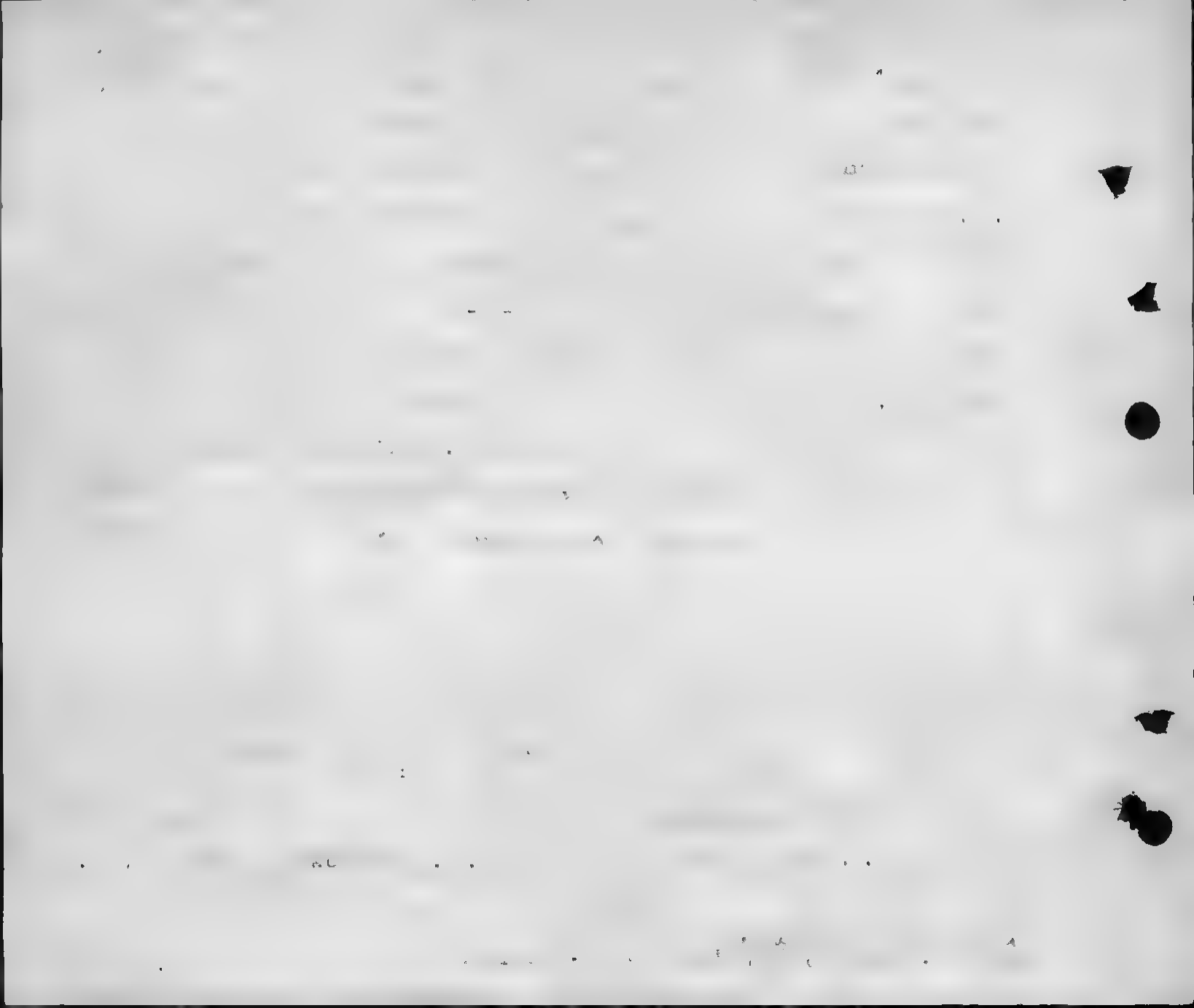


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 1 of 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9368											
CERTIFICATE OF DEATH											
Items 23 File 6292 8/10/61 174											
09359											
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 17 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 9209 Bulls Run Pkwy	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		3. NAME OF DECEASED (Type or print) Thad Patrick		4. DATE OF DEATH August 3 1961		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH 9-21-25		9. AGE (In years last birthday) 35 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitary Engineer		11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William T. Patrick	
14. MOTHER'S MAIDEN NAME Lula Bond		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Carolyn M. Patrick Same as #2 above		17. INFORMANT Carolyn M. Patrick Same as #2 above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE Conditions, if any, which gave rise to immediate cause (b) RUPTURED INTRACRANIAL ANEURYSM (c) 17 DAYS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 17 DAYS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 330X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 17, 1961 to August 3, 1961 , that (we) last saw the deceased alive on August 3, 1961 , and that death occurred at 9:40 PM from the causes and on the date stated above		22a. SIGNATURE R.W. Mackie		22b. DATE SIGNED August 4, 1961		22c. PHYSICIAN'S NAME (Type) R.W. MACKIE CAPT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. REC'D BY REGISTRAR August 7 '61	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/61		23c. NAME OF CEMETERY OR CREMATORY Capitol Mem. Gardens		23d. LOCATION (City, town or county) (State) Austin, Texas		23e. REC'D BY REGISTRAR August 7 '61		23f. REGISTRAR'S SIGNATURE Arthur L. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9369

CERTIFICATE OF DEATH

09360

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Takoma Park, Md.
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Takoma Park, Md.
d. STREET ADDRESS 18202 Flower Ave.

3. NAME OF DECEASED (Type or print) JULIUS CARL PETER R.
First Middle Last

4. DATE OF DEATH Aug. 5 1961
Month Day Year

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb. 5 1894
Last First Middle

9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 67 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Revisor & Herald
10b. KIND OF BUSINESS OR INDUSTRY Chicago, Illinois
11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Julius C. Peter R.
14. MOTHER'S MAIDEN NAME Lena Kramer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO (b) Atherosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year 19
Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/5/61 to 8/5/61, that (I) (we) last saw the deceased alive on 8/5/61, 1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

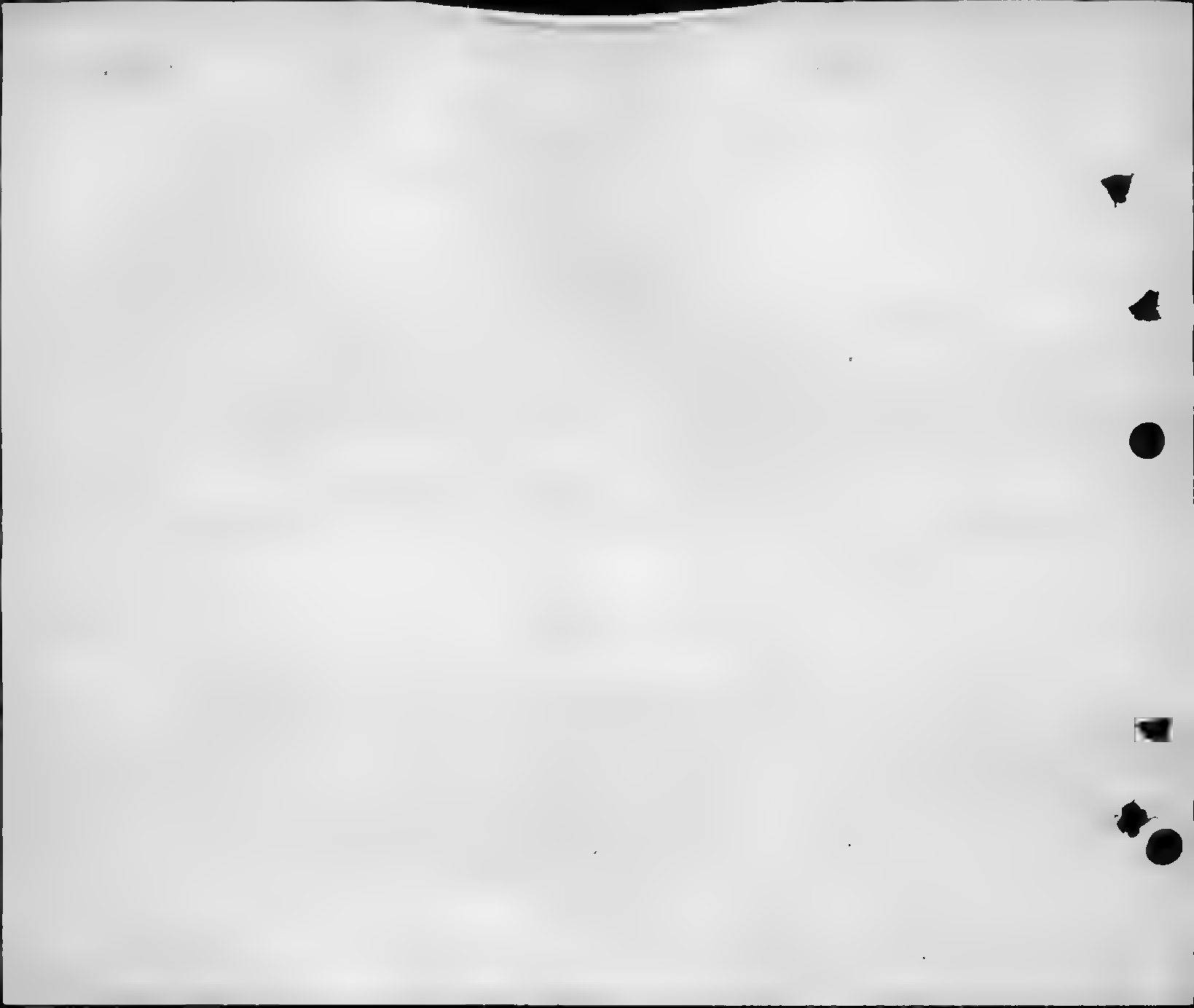
22a. SIGNATURE Chas H. Molohon M.D.
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Chas H. Molohon
22d. ADDRESS 7600 Carroll Ave. TP

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Aug-10-61
23c. NAME OF CEMETERY OR CREMATORY Rose Hill
23d. LOCATION (City, town or county) Dorsey Springs, Michigan

24. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Hall ADDRESS 254 Canal St NW
25a. REC'D BY REGISTRAR DATE AUG 8 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



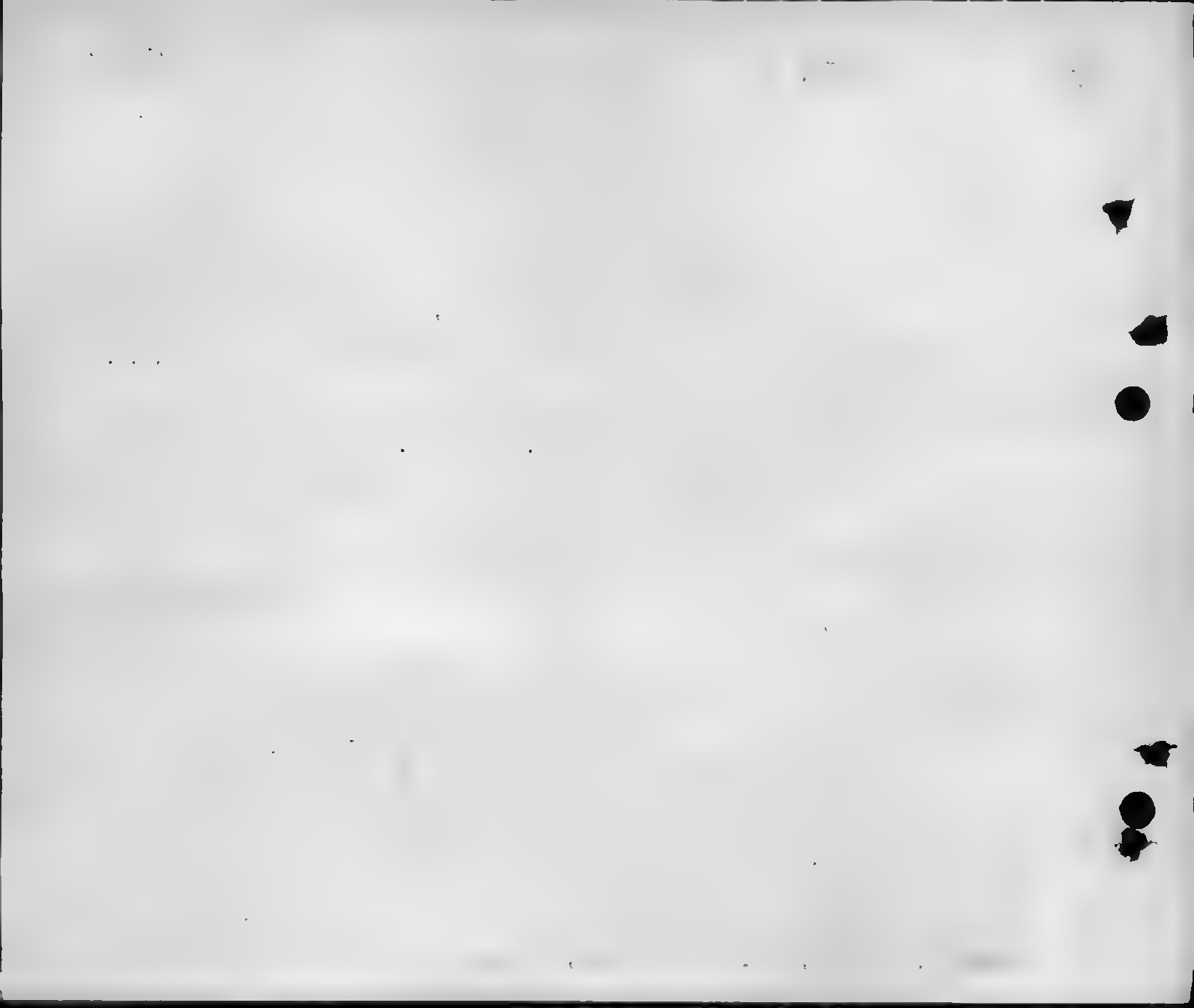
TO HOSPITAL OR AT RESIDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. It must be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
9370		09361	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admiss on)	
a. COUNTY	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	a. STATE	b. COUNTY
MONTGOMERY	MARYLAND	MARYLAND	MONTGOMERY
c. LENGTH OF STAY IN	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	d. STREET ADDRESS
SILVER SPRING	818 GIST AVENUE	SILVER SPRING	818 GIST AVENUE
3. NAME OF DECEASED (Type or print)	First Middle Last	4. DATE OF DEATH	Month Day Year
MARTHA MACLEOD PLUNKETT		AUGUST	29, 19 61
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NOVEMBER 2, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TEACHER-RETIRED		NORTH CAROLINA	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
HENRY MACLEOD	UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		MR. CHARLES T. PLUNKETT	818 GIST AVENUE SILVER SPRING, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE INTESTINAL HEMORRHAGE (b) 578X DUE TO (c) DIABETES MELLITUS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 Hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter no more of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from 1948 to 29 AUG., 1961, that (I) (we) last saw the deceased alive on 29 AUG., 1961, and that death occurred at 3 P.M., from the causes and on the date stated above.			
22a. SIGNATURE L.B. Snow M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 8/29/61			
22c. PHYSICIAN'S NAME (Type) LEE B. SNOW 22d. ADDRESS 7950 NEW HAMPSHIRE AVENUE			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 9/1/61 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY 23d. LOCATION (City, town or county) ARLINGTON, VIRGINIA (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. PIMPHREY, INC. 8434 GEORGETTA AVENUE SILVER SPRING, MARYLAND 25a. REGISTRY REGISTRAR DATE AUG 31 61 25b. REGISTRAR'S SIGNATURE Arthur L. Huns			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9371

09362

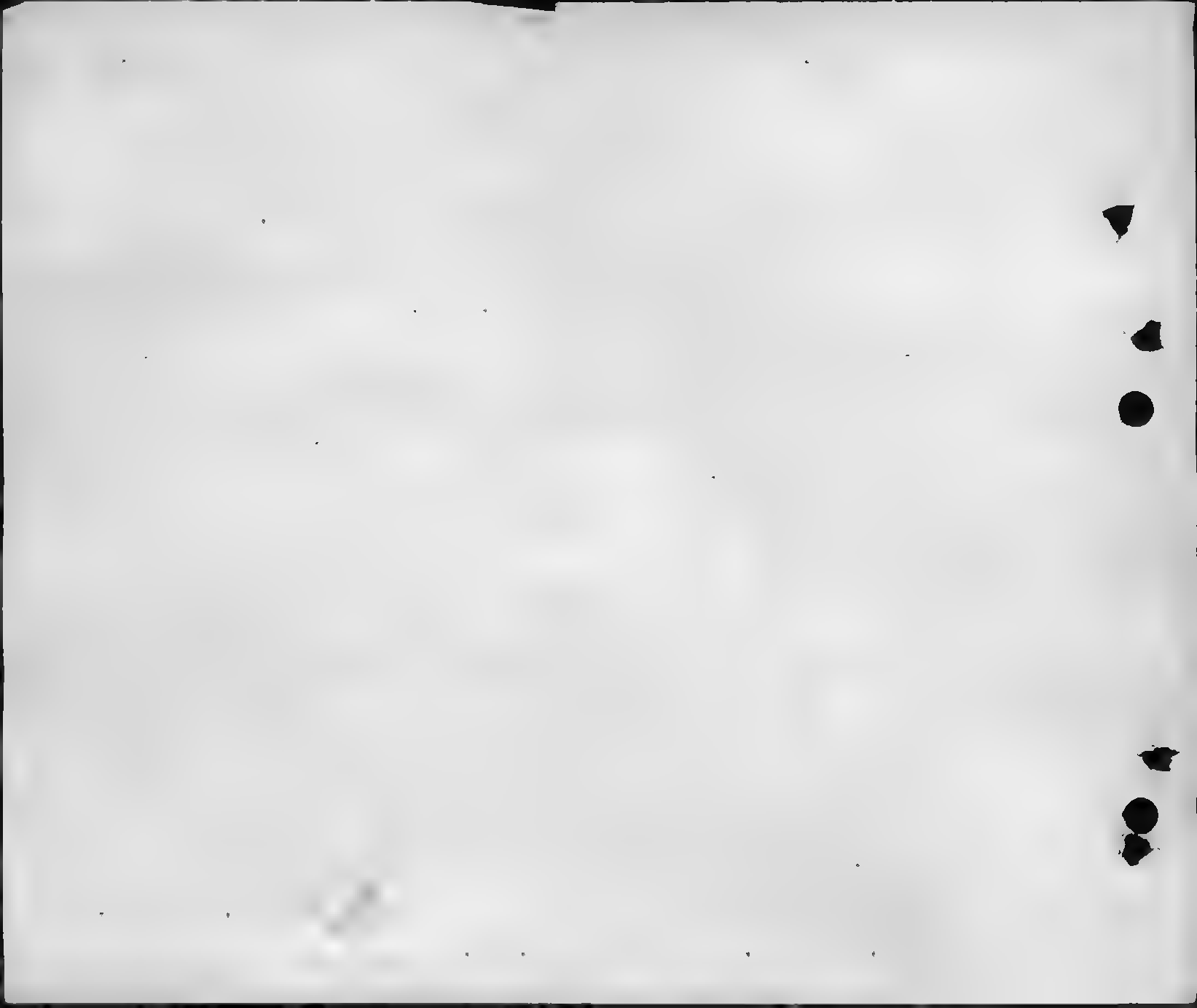
1. PLACE OF DEATH
a. COUNTY **MONTGOMERY** **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **OLNEY** c. LENGTH OF STAY IN 1b **14 DAYS**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **MONTGOMERY GENERAL HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **MARYLAND** b. COUNTY **MONTGOMERY**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **GAITHERSBURG** d. STREET ADDRESS **15 DESELLM AVE.** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last **THOMAS HERBERT POPE**
4. DATE OF DEATH Month Day Year **AUGUST 22 1961**
5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH **SEPT. 19, 1872** 9. AGE (In years, last birthday) **80 yrs.** IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **RETIRED- GOVERNMENT** 10b. KIND OF BUSINESS OR INDUSTRY **MARYLAND** 11. BIRTHPLACE (Country & State, or foreign country) **U.S.** 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME **JOSEPH POPE** 14. MOTHER'S MAIDEN NAME **MATILDA THOMPSON**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address

HOSPITAL RECORDS

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Emboli, Pulmonary**
DUE TO **Thrombophlebitis, femoral, right.**
Conditions, any, which gave rise to immediate cause (b) **right.**
(c) **right.**
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **Aug. 21, 1961** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from **Aug. 19, 1961** to **Aug. 22, 1961**, that (I) (we) last saw the deceased alive on **Aug. 21, 1961**, and that death occurred at **9:00** M. from the causes and on the date stated above.
22a. SIGNATURE **J. Schumacher** M.D. 22b. DATE SIGNED **8-22-61**
22c. PHYSICIAN'S NAME (Type) **J. SCHUMACHER, M. D.** 22d. ADDRESS **GAITHERSBURG, MARYLAND**
23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 23b. DATE THEREOF **8-24-61** 23c. NAME OF CEMETERY OR CREMATORY **24 Wesley Grove Cemetery** 23d. LOCATION (City, town or county) (State) **Woodfield, Md.**
24. FUNERAL DIRECTOR'S SIGNATURE **Ernest C. Gartner.** ADDRESS **Gaithersburg, Md.** 25a. REC'D BY REGISTRAR **Aug 24 '61** 25b. REGISTRAR'S SIGNATURE **Carl J. Hines**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

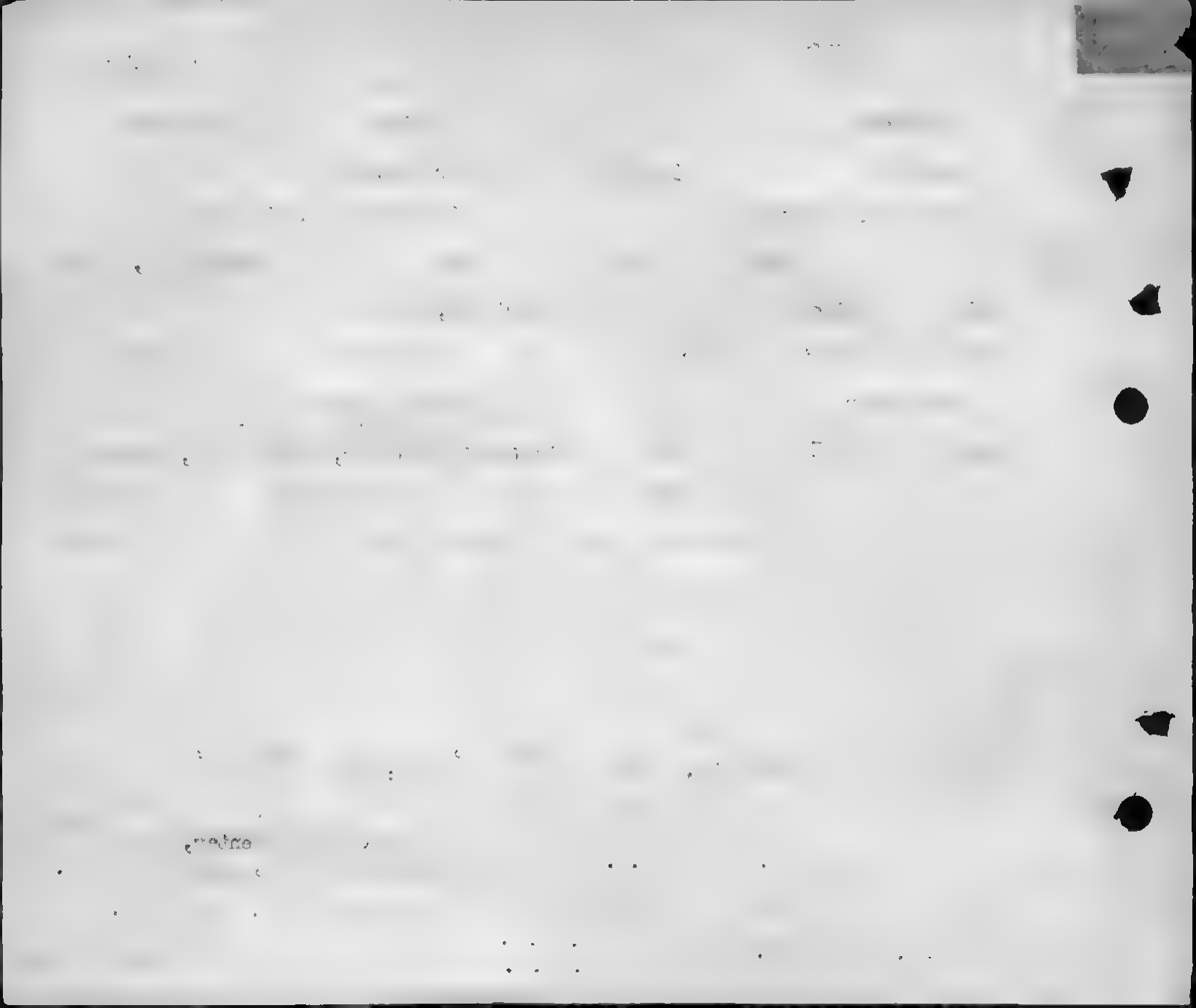
VR A15 (4)
15M 9/60

9372

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09363

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 31 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia		b. COUNTY Arlington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 3925 Chesterbrook Road		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY CLAY PRYOR		4. DATE OF DEATH Month August Day 10 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1906		9. AGE (in years last birthday) 55 yrs.		10. F UNDER 1 YEAR <input type="checkbox"/> F UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Management Analyst		10b. KIND OF BUSINESS OR INDUSTRY Army		11. BIRTH PLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Pryor		14. MOTHER'S MAIDEN NAME Carrie Winters		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. (If known) None			
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure With Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amyloidosis with Multiple Myeloma DUE TO (c) 2 Months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 D.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 to August 10, 1961 , that (I) (we) last saw the deceased alive on August 10, 1961 , and that death occurred at 10:55 AM on the causes and on the date stated above.		22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED 8/10/61		22c. PHYSICIAN'S NAME (Type) Robert H. Levin M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22e. REC'D BY REGISTRAR Arthur S. Knead		22f. REGISTRAR'S SIGNATURE August 14 '61		22g. LOCATION (City, town or county) (State) Ft. Myer, Va.			
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 8/14/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Ft. Myer, Va.		23e. NAME OF CEMETERY OR CREMATORY Washington 9, D.C.		23f. LOCATION (City, town or county) (State) Washington 9, D.C.		23g. NAME OF CEMETERY OR CREMATORY Washington 9, D.C.		23h. LOCATION (City, town or county) (State) Washington 9, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. ADDRESS 2901 14th St. N.W.		24b. CITY Washington 9, D.C.		24c. STATE D.C.		24d. ZIP CODE 20004		24e. PHONE NO. 200-4500		24f. FAX NO. 200-4500		24g. TELETYPE NO. 200-4500			



17

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death).

1

A15 14
15M 9/60

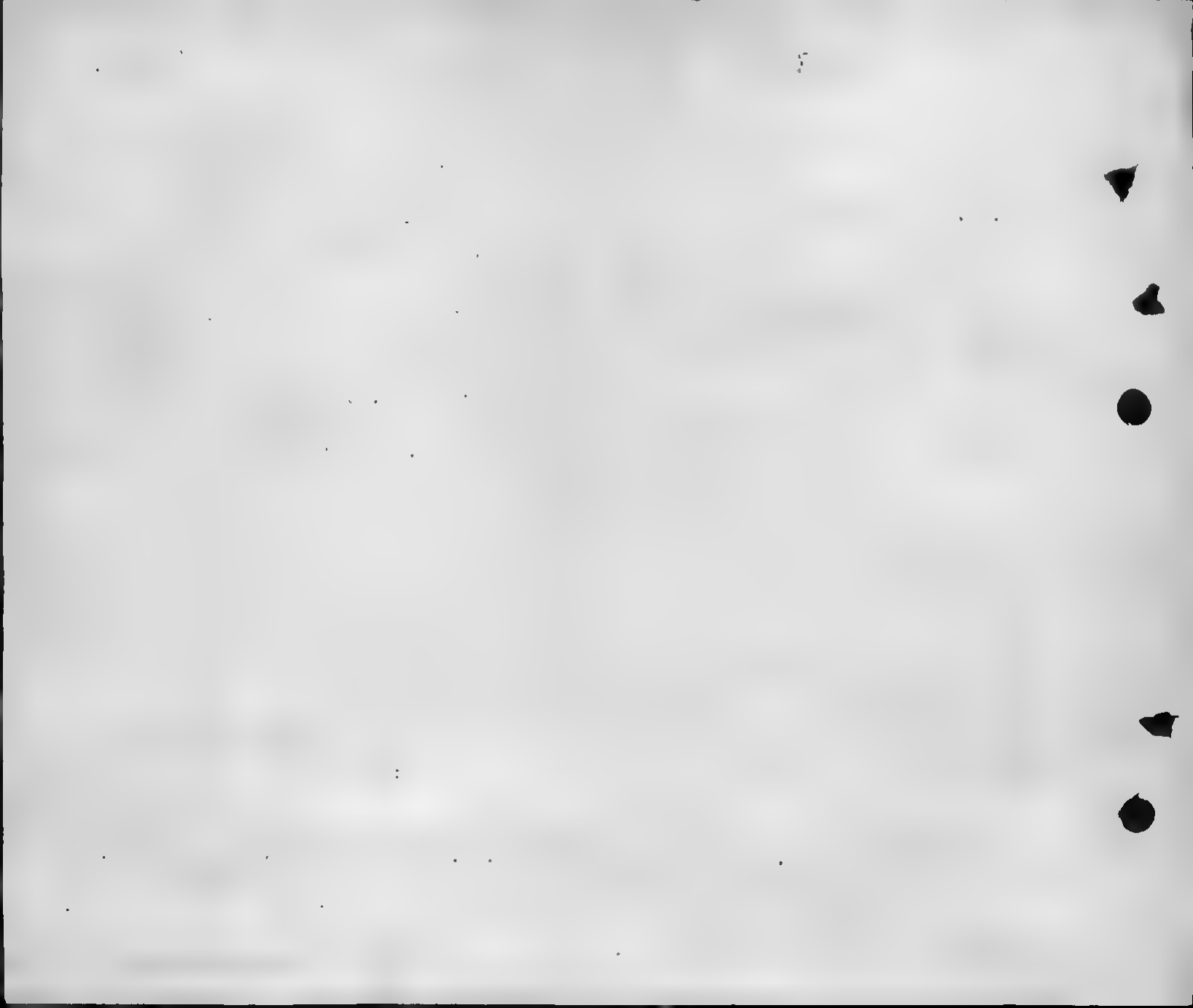
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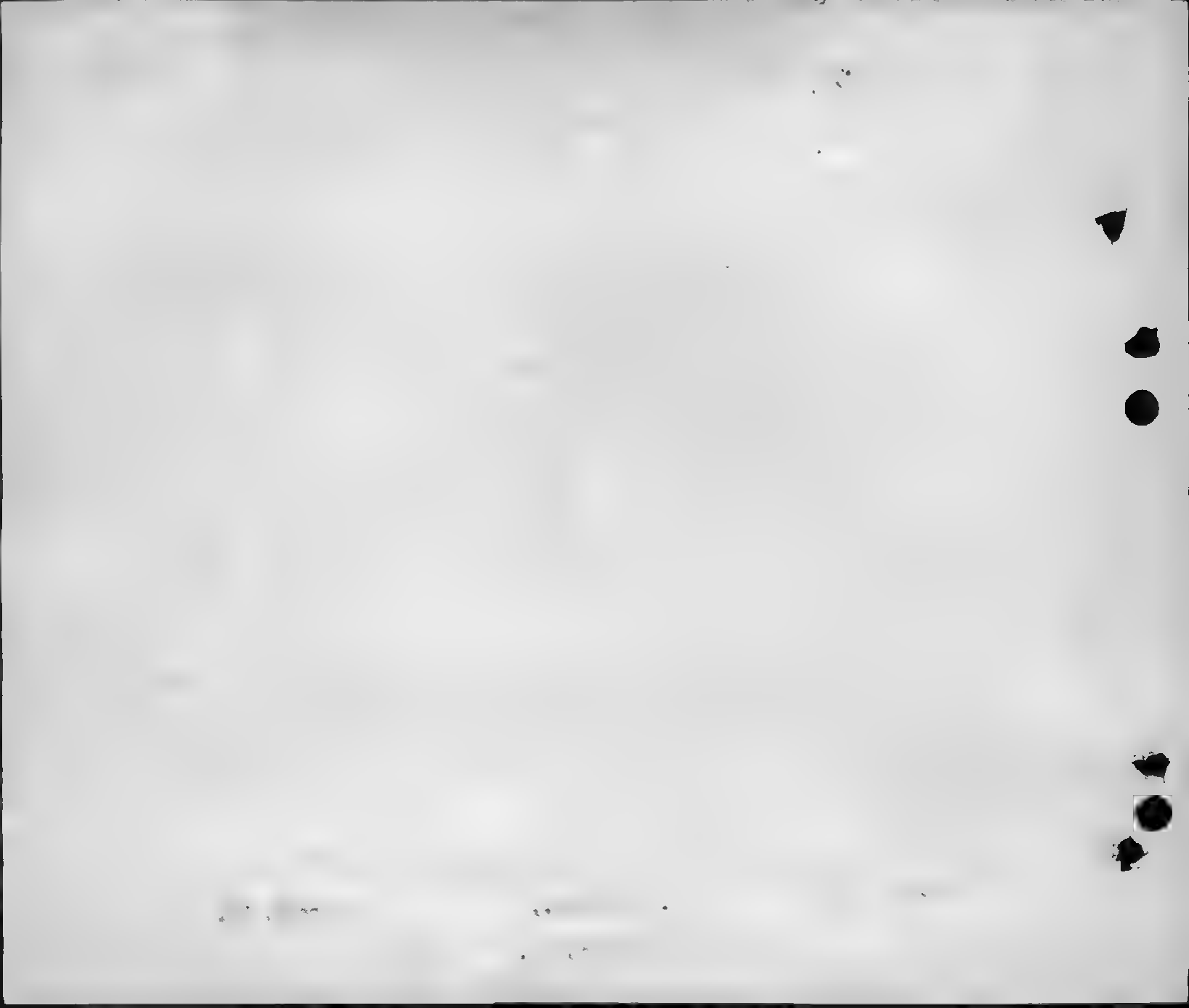
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia		b. COUNTY Herndon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt # 1		d. STREET ADDRESS Rt # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael		First James		Middle Rentfrow		Last August		4. DATE OF DEATH August		31		19 61		5. SEX Male			
6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 18, 1961		9. AGE (In years last birthday) 13		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jess W. Rentfrow			
14. MOTHER'S MAIDEN NAME Darlene M. Caldwell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT (M) Darlene M. Rentfrow Same as #2 above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease; Transposition of Great Vessels DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Herndon		20g. (County) Va.		20h. (State) Va.		21. I certify that (this hospital) attended the deceased from August 26, 1961, to August 31, 1961, that (we) last saw the deceased alive on August 31, 1961, and that death occurred at 1:10 AM, from the causes and on the date stated above.		22a. SIGNATURE James E. McClenathan M.D.		22b. DATE SIGNED August 31, 1961	
22c. PHYSICIAN'S NAME (Type) JAMES E. MCCLLENATHAN, CDR MC USN		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2 Sept 1961		23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cemetery		23d. LOCATION (City, town or county) Herndon		23e. REC'D BY REGISTRAR SEP 5 '61		23f. REGISTRAR'S SIGNATURE Arthur S. House		24. FUNERAL DIRECTOR'S SIGNATURE Green Funeral Home, Herndon, Va.		25. REGISTRAR'S SIGNATURE	



Arthur L. Kraus

VS. A15M
5M 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9375

CERTIFICATE OF DEATH

Item 7 Film G292 8/15/61

09368

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK
c. LENGTH OF STAY IN lb. TAKOMA PARK
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8017 BARRON

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD. b. COUNTY MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK
d. STREET ADDRESS 8017 BARRON
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last Edward A. Roberts

4. DATE OF DEATH Month Day Year August 4 - 1961

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Printing Business 10b. KIND OF BUSINESS OR INDUSTRY Pittsburgh Penn 11. BIRTHPLACE (Country & State, or foreign country) USA
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Eugene Roberts 14. MOTHER'S MAIDEN NAME Anna Enck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Hazel L. Roberts Address 8017 Barron St. Takoma Park

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture of Cerebral Arteries, Contusion
DUE TO (b) Cerebral Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Cerebral Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 Jun 19 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jun 19 1961 to Aug 4 1961, that (I) (we) last saw the deceased alive on Aug 4 1961, and that death occurred at 8017 Barron St, from the causes and on the date stated above.

22a. SIGNATURE Chas. H. McLaughlin M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED Aug 4 1961

22c. PHYSICIAN'S NAME (Type) Chas. H. McLaughlin 22d. ADDRESS 7600 Carroll Ave Takoma Park

23a. BURIAL CREMATION REMOVAL (Specify) 23b. DATE THEREOF Aug 7 1961 23c. NAME OF CEMETERY OR CREMATORY St. Lincoln 23d. LOCATION (City, town or county) (State) Blacksburg Va

24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus ADDRESS 254 Carroll St NW DC 25a. REC'D BY REGISTRAR DATE AUG 8 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

VR A15 (4)
15M 9/60



CERTIFICATE OF DEATH

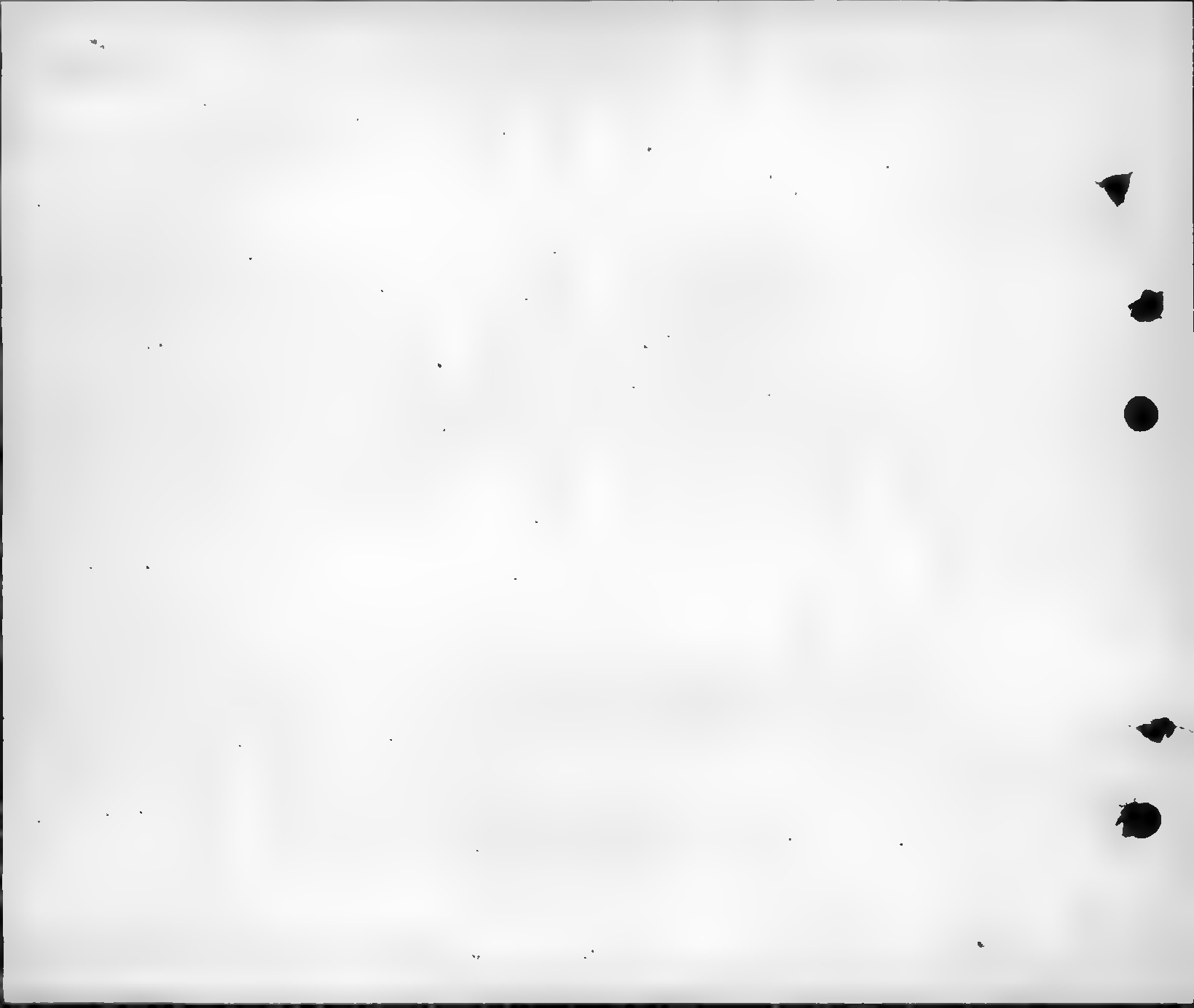
Reg. Dist. No.

9376

9369

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <u>Poolesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>C. HARLES E. ROBINSON</u> First Middle Last		4. DATE OF DEATH <u>AUGUST 3</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 27, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Hollings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>INFORMANT Mary Jackson -</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CACHEXIA</u> DUE TO <u>17</u> Conditions if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>METASTATIC CARCINOMA</u> (c) <u>CARCINOMA OF PROSTATE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>4 YEARS</u> <u>6 YEARS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>3 Aug</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3 AUG</u> , 19 <u>61</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>3 AUG. 1961</u>			
ACTUAL SIGNATURE <u>John G. Fawcett</u>		M.D. <u>DAWSONVILLE</u>	
PHYSICIAN'S NAME (Type) <u>JOHN G. Fawcett</u>		<u>P.O. BOYD, MARYLAND</u>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <u>8/7/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elizav. Methodist</u>	22d. LOCATION (City, town, or county) <u>Poolesville, Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>AUG 11 '61</u> DATE	
ADDRESS <u>Poolesville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR FUNERAL HOME: This certificate must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9377

CERTIFICATE OF DEATH

093770

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Westmont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				d. STREET ADDRESS <u>120 French Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>May</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-26-88</u>	
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>							
13. FATHER'S NAME <u>Edwin Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Washington San & Hosp. Takoma Park Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434 Congestive Cardiac Failure</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 Months</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction - old</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 19 <u>61</u> to <u>8/17</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>8-17-</u> 19 <u>61</u> , and that death occurred at <u>4:15</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Robert A. Hare</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				22d. ADDRESS <u>7600 Carroll Ave. T.P.K. Md</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 21, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reconst Wood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Camden New Jersey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				25a. REG'D BY REGISTRAR <u>254 Carroll St. Wash, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

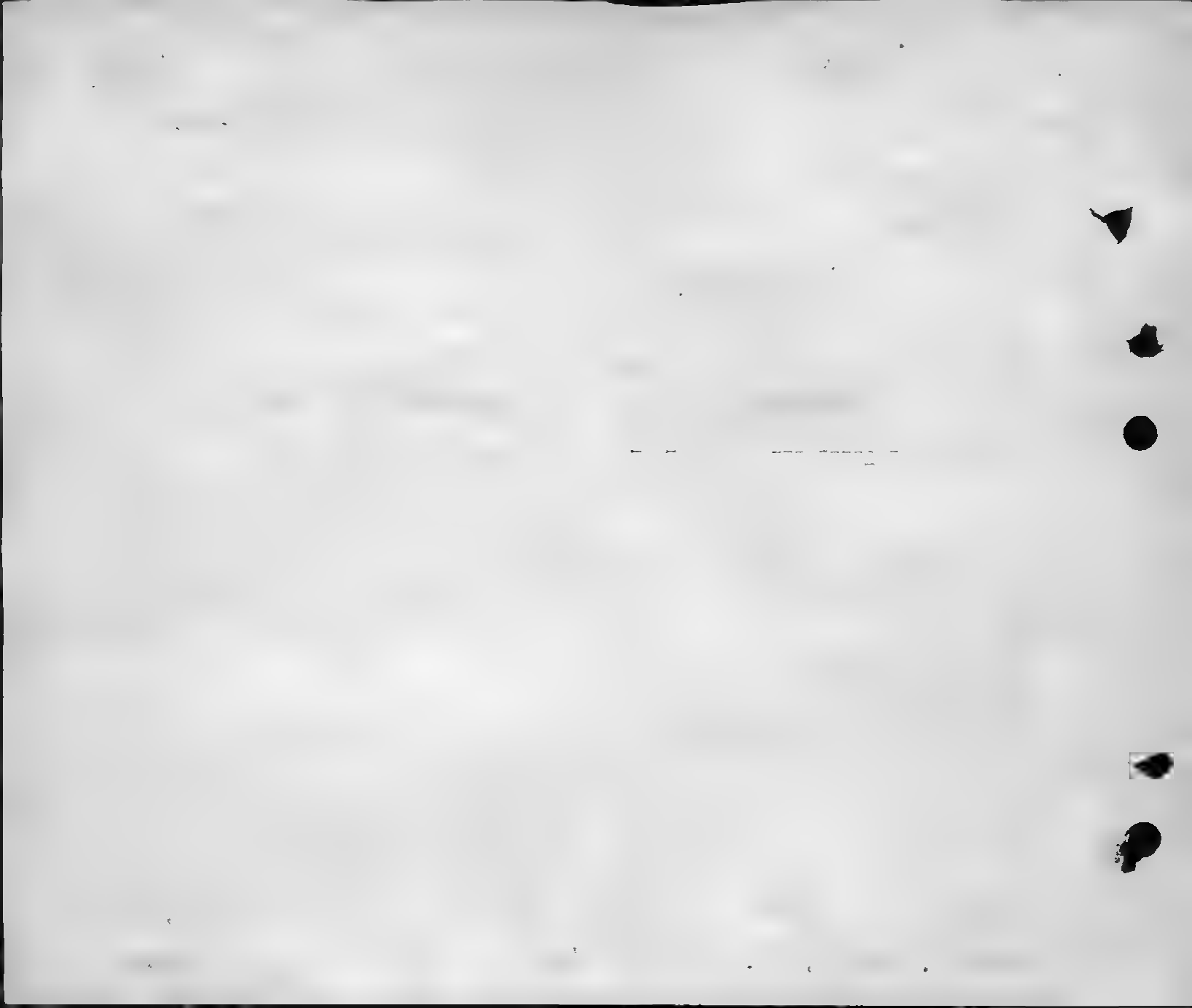
9378

09371

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp. t., give street address) <u>Washington Sanitarium #4 Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>13402 Keating Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Lewis</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 10, 1906</u>	9. AGE (In years last birthday) <u>54</u> IF UNDER 1 YEAR: Months <u>3</u> Days <u>5</u> IF UNDER 24 HRS.: Hours <u>3</u> Min. <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Manager - Montgomery County</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Dispensary</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>					
13. FATHER'S NAME <u>Columbus George</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Medbetter</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-05-3463</u>			
17. INFORMANT <u>Hospital Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4:30 P.M.</u> DUE TO <u>Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial infarction</u> (c) <u>Coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs 40 min</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	
21. I certify that (I) (this hospital) attended the deceased from <u>13 Aug., 1961</u> , to <u>13 Aug., 1961</u> , that (I) (we) last saw the deceased alive on <u>13 Aug., 1961</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Arthur W. W. W.</u>		22b. DATE SIGNED <u>13 Aug 1961</u>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>7722 Maple Ave, Takoma Park 12, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/15/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City, town or county) <u>Montgomery County, Maryland</u> (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond D. A. Ziska</u>		25a. REC'D BY REGISTRAR <u>AUG 16 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Pumphrey, Inc.</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur E. Pumphrey</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
ISM 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9379

09372

M

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Boyds</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lennie R. Rose</i>				4. DATE OF DEATH Month Day Year <i>Aug. 3 1961</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/5/07</i>	
9. AGE (In years last birthday) <i>53</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>Noah Farmer</i>				14. MOTHER'S MAIDEN NAME <i>Annie Smallwood</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Claude Rose / same as above</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute hemorrhagic PANCREATITIS</i> <i>SB 7.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>8/2 1961</i> to <i>8/3 1961</i> , that (I) (we) last saw the deceased alive on <i>8/3 1961</i> , and that death occurred at <i>8 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert G. Brewer</i> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>ROBERT G. BREWER</i>				22d. ADDRESS <i>8218 WISCONSIN AVE. BETH</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/7/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Yellow Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Pike County, Kentucky</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Chas L. Mohsawth</i> ADDRESS <i>Damascus, Md.</i>				25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE <i>Catherine S. Hester</i>	
				DATE <i>AUG 7 '61</i>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09373

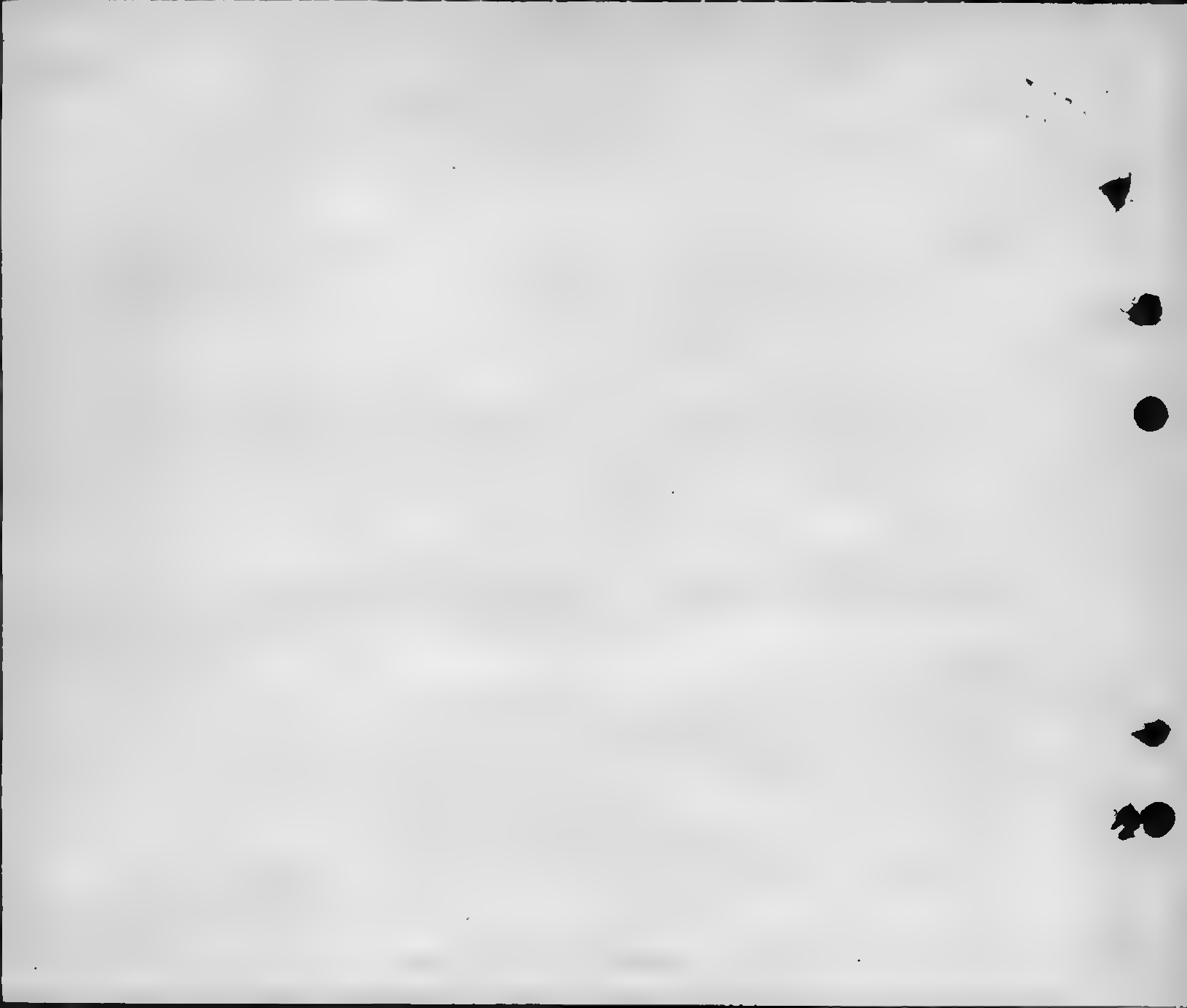
1
FOR STATE
HEALTH DEPT

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN IB <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bradley Blvd + Durbin Rd.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> <u>8-X-3</u>			
3. NAME OF DECEASED (Type or print) <u>Hiram Edward Rosenbaum</u>				d. STREET ADDRESS <u>1145 Murray Ave</u>			
4. DATE OF DEATH <u>Aug 2 1961</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-1911</u>	
9. AGE (in years, last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>1</u> Min. <u>50</u>		IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>1</u> Min. <u>50</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW 2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Ruby Rosenbaum-Wife-same 2d</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>8-2-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Happy Valley Mem. Park</u>		22d. LOCATION (City, town, or country) <u>Elizabethton, Tennessee</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				24. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>			
25. A15ME 5M 9/60				26. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **19374**

9381

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9855 SINGLETON RD		d. STREET ADDRESS 9855 SINGLETON RD.	
3. NAME OF DECEASED (Type or print) First Middle Last ISRAEL A ROSENBLUM		4. DATE OF DEATH Month Day Year AUGUST 5 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 2, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER-STORE		10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING	
11. BIRTHPLACE (State or foreign country) WASH DC		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME MAX ROSENBLUM		14. MOTHER'S MAIDEN NAME BLUME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MORRIS ACKERMAN		Address 7307 ASHBOROUGH CHCH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) 2 YEARS			INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUGUST, 1953 to AUGUST, 1961 , that I last saw the deceased alive on AUGUST 3, 1961 , and that death occurred at 6:05 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert L. Krichmar		ADDRESS (Street, city or town, state) 7733 ALASKA AVENUE NW WASHINGTON 12 D.C.	
PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR		DATE SIGNED AUGUST 5 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUG. 6, 1961	22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	22d. LOCATION (City, town, or county) (State) FALLS CHURCH Va.
23. FUNERAL DIRECTOR'S SIGNATURE B. D. [Signature]		24. REC'D BY REGISTRAR DATE AUG 9 '61	
ADDRESS 3501-14 ST NW		24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

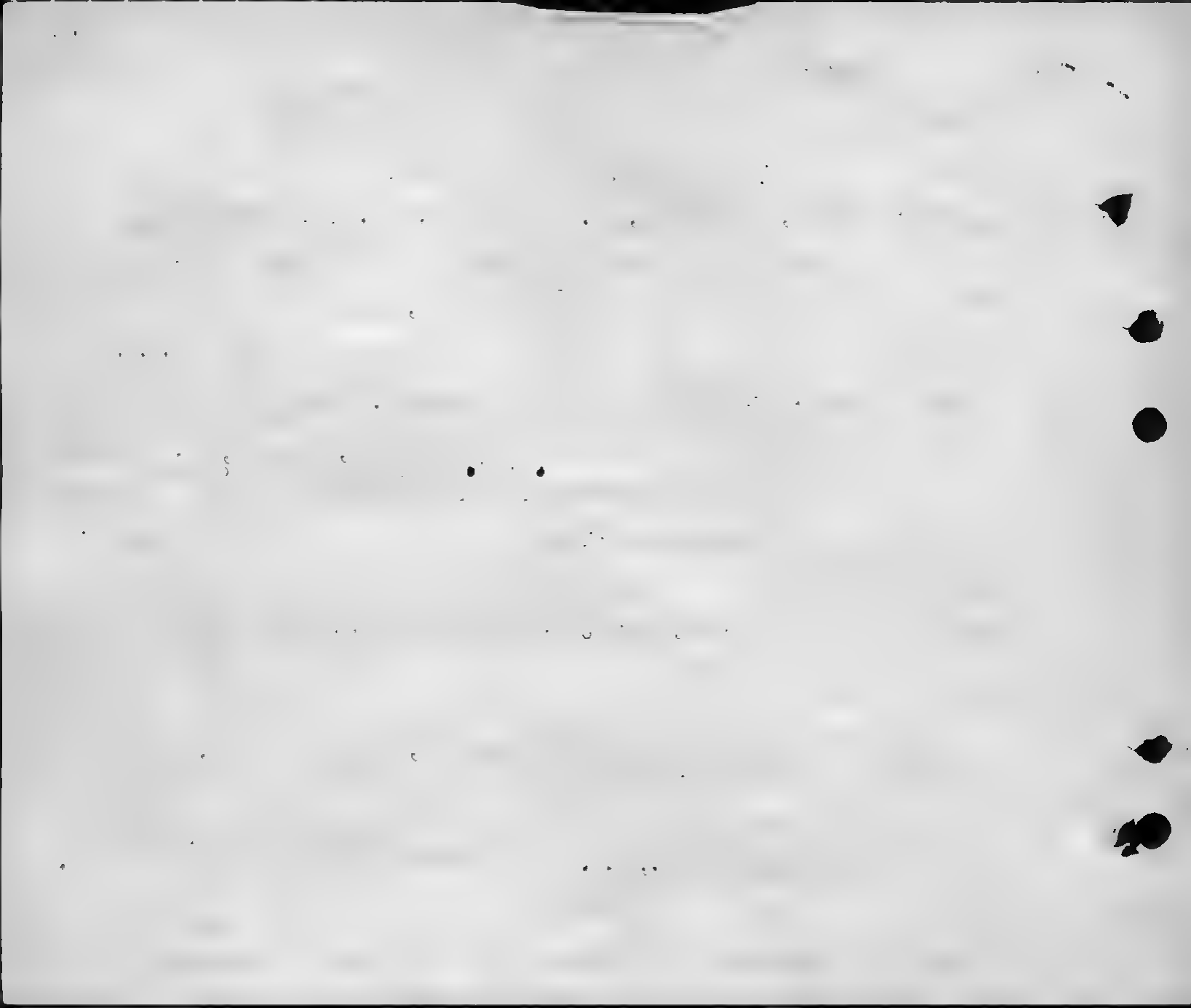
CERTIFICATE OF DEATH

09375

9382

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 5 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Kentucky			
3. NAME OF DECEASED (Type or print) Sergio Bastos		b. COUNTY Harlan			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		8. DATE OF BIRTH Santos January 18, 1960	
13. FATHER'S NAME Ottao A. Santos		14. MOTHER'S MAIDEN NAME Suzanna B. Fausto			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. None		17. INFORMATION The Medical Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure with pulmonary edema and (b) Tetralogy of Fallot (c) Postoperative Blalock anastomosis of right subclavian artery to right pulmonary artery INTERVAL BETWEEN ONSET AND DEATH 6 weeks Congenital					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION None					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (OF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from... August 14, 1961 to August 19, 1961 that (I) (we) last saw the deceased alive on... August 19, 1961 and that death occurred at... 11:00AM from the causes and on the date stated above					
22a. SIGNATURE THOMAS MERRIGAN, JR., M.D.		22b. DATE SIGNED 8/19/61			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 23, 1961		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City, town or county) Harlan		23e. (State) Kentucky			
24. FUNERAL DIRECTOR'S SIGNATURE Robert G. Langhrey		24b. ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE AUG 22 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. H...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



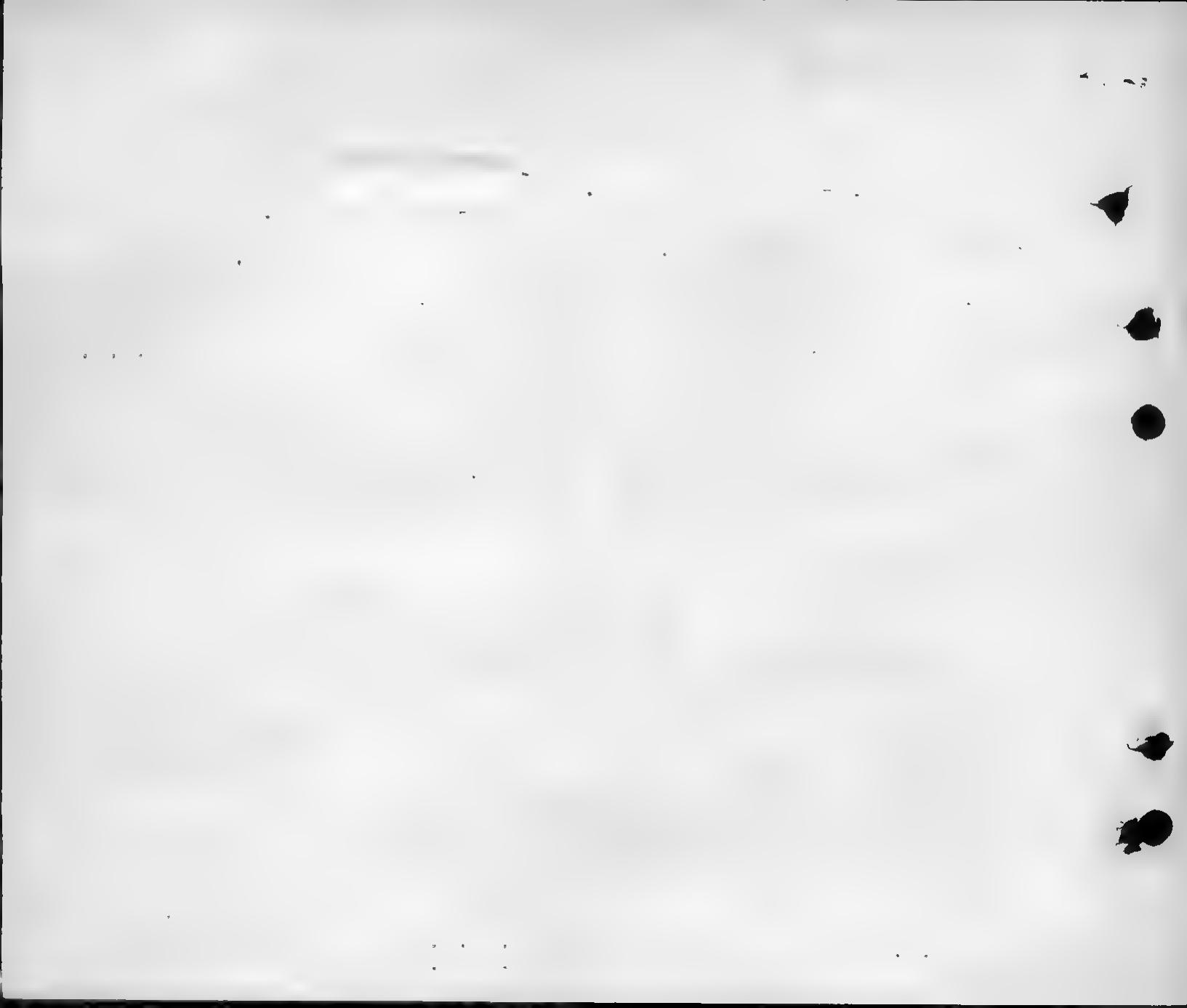
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9383

09376

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION Shannon Nursing Home				e. STREET ADDRESS 952-East-West Hwy.			
3. NAME OF DECEASED (Type or print) First Middle Last Angelo J. Scandolos				4. DATE OF DEATH Month Day Year Aug. 11 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25-1896		9. AGE (In years lost birthday) 65 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) Resturant Owner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Scandolos				14. MOTHER'S MAIDEN NAME Helen Margelos			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO ?		17. INFORMANT Address Nursing Home Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1958 to Aug 1961 , that (I) (we) last saw the deceased alive on Aug 10 1961 , and that death occurred at 2:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE George Dickfield				22b. DATE SIGNED 8/11/61		22c. PHYSICIAN'S NAME (Type) HOWARD E. DICKFIELD	
22d. ADDRESS 6826 Regg's Rd Hyattsville				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8/14/61		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				25a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9384

09377

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bethesda**
c. LENGTH OF STAY IN 1b **29 Days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **The Clinical Center**

2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before admission)
a. STATE **Maryland** b. COUNTY **Montgomery**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Takoma Park**
d. STREET ADDRESS **716 Forston Drive**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Middle Last **ALVIN VERNON SCHEIBLE**
4. DATE OF DEATH Month Day Year **August 3, 19 61**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **June 4, 1928**
9. AGE (In years last birthday) **33** yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (County & State or foreign country) **Virginia** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Charles Scheible** 14. MOTHER'S MAIDEN NAME **Eldora King**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **The Medical Record**
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Septicemia**
204.3 DUE TO **Acute lymphocytic leukemia**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH **36 hours**
6 months

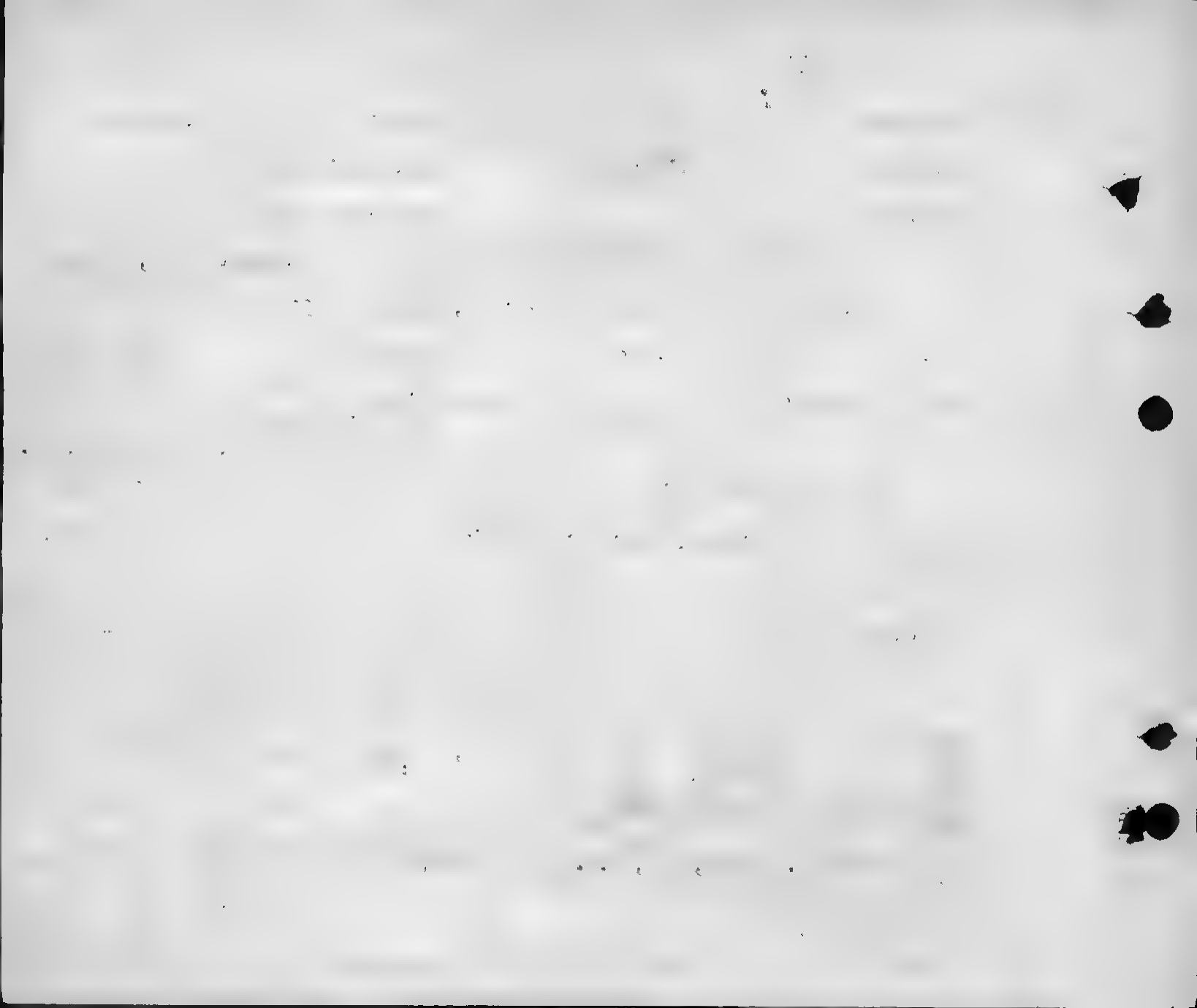
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) **Mongolism** 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While ☐ Not While ☐ at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **July 5, 1961** to **August 3, 1961** that (I) (we) last saw the deceased alive on **August 3, 1961** and that death occurred at **7:00AM** from the causes and on the date stated above.
22a. SIGNATURE **Geo. H. Porter III** M.D. 22b. DATE SIGNED **8/3/61**
22c. PHYSICIAN'S NAME (Type) **GEORGE H. PORTER, III, M.D.** 22d. ADDRESS **The Clinical Center, National Institutes of Health, Bethesda 14, Maryland**

23a. BURIAL CREMATION, 23b. DATE THEREOF **Burial Aug 7-1961** 23c. NAME OF CEMETERY OR CREMATORY **Thorpcrest Hill** 23d. LOCATION (City, town or county) (State) **Dist Capital & H. The D.C.**
24. FUNERAL DIRECTOR'S SIGNATURE **Arthur J. Hall** ADDRESS **254 Carroll St N.W.** 25a. REC'D BY REGISTRAR **DATE AUG 7 '61** 25b. REGISTRAR'S SIGNATURE **Arthur J. Hall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9385

CERTIFICATE OF DEATH

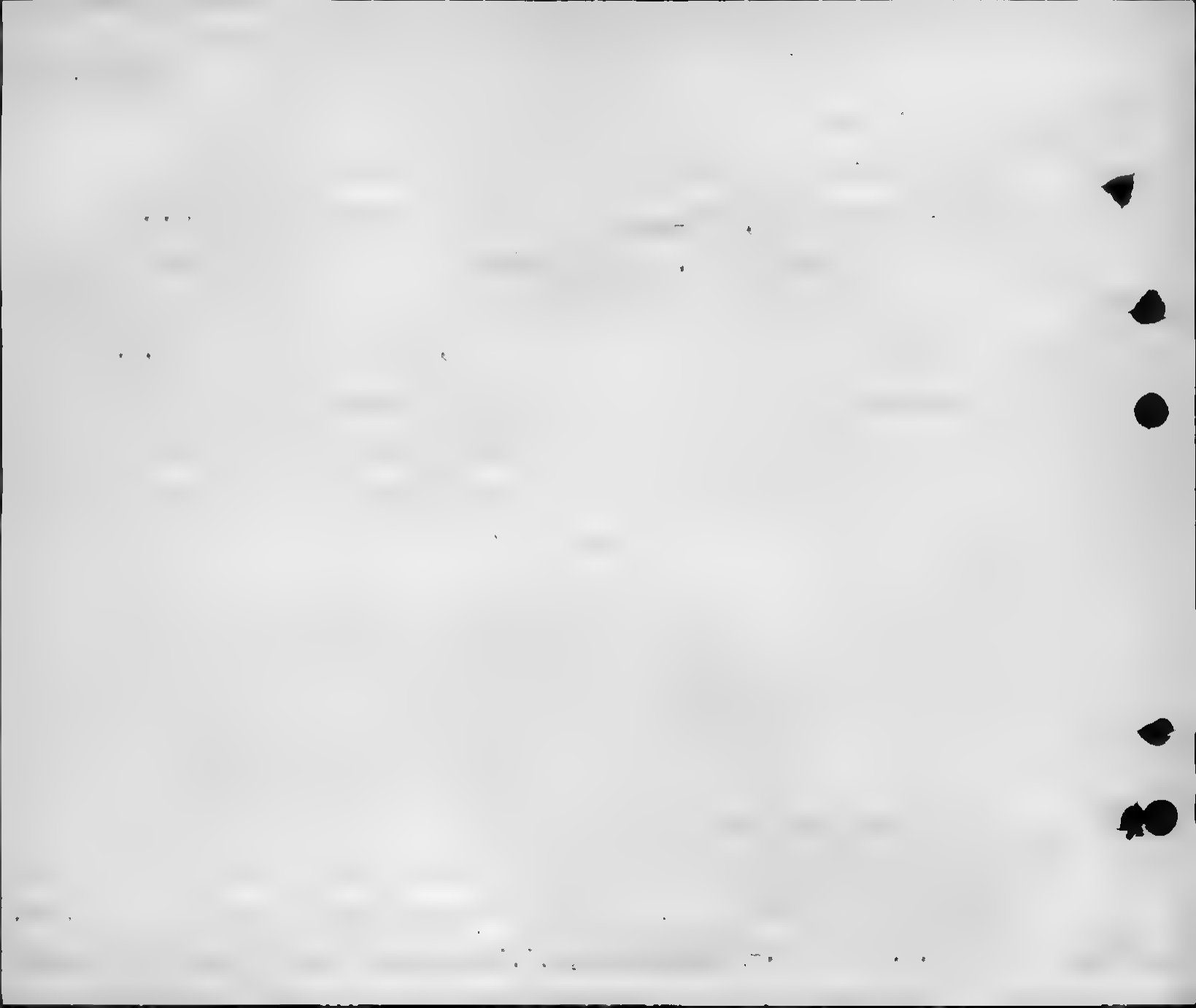
09378

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bella Vista Nursing Home 571 University Blvd., East-Atxx		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DC b. COUNTY -- c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3724 New Hampshire Ave. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice L. Shadle 5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11/21/1872 9. AGE (in years) 88 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH August 11 19 61 Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Ava, New York 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unobtainable 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no		14. MOTHER'S MAIDEN NAME Unobtainable 17. INFORMANT Records at Nursing Home-- See #1 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis & Congestive Heart Failure DUE TO (b) Generalized arteriosclerosis DUE TO (c) 8 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15, 1957 to Aug 11, 1961, that (I) (we) last saw the deceased alive on 8-11-19 57, and that death occurred 8:15 PM, from the causes and on the date stated above.			
22a. SIGNATURE CHAS W. HARNSDERGER 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 8-11-61 22d. ADDRESS 4201 NEW HAMPSHIRE AVE N.W.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 8/15/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery 23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 25c. DATE AUG 15 '61		25d. ADDRESS 2901 11th St. N.W. Washington 9, D.C.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 2 of this certificate has been signed by the funeral director. Page 3 of this certificate has been signed by the funeral director. Page 4 of this certificate has been signed by the funeral director. Page 5 of this certificate has been signed by the funeral director. Page 6 of this certificate has been signed by the funeral director. Page 7 of this certificate has been signed by the funeral director. Page 8 of this certificate has been signed by the funeral director. Page 9 of this certificate has been signed by the funeral director. Page 10 of this certificate has been signed by the funeral director. Page 11 of this certificate has been signed by the funeral director. Page 12 of this certificate has been signed by the funeral director. Page 13 of this certificate has been signed by the funeral director. Page 14 of this certificate has been signed by the funeral director. Page 15 of this certificate has been signed by the funeral director. Page 16 of this certificate has been signed by the funeral director. Page 17 of this certificate has been signed by the funeral director. Page 18 of this certificate has been signed by the funeral director. Page 19 of this certificate has been signed by the funeral director. Page 20 of this certificate has been signed by the funeral director. Page 21 of this certificate has been signed by the funeral director. Page 22 of this certificate has been signed by the funeral director. Page 23 of this certificate has been signed by the funeral director. Page 24 of this certificate has been signed by the funeral director. Page 25 of this certificate has been signed by the funeral director. 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YR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY **Montgomery**
b. CITY OR TOWN (if outside the corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **District of Columbia**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
4701 Connecticut Ave. N.W. Apt 401

3. NAME OF DECEASED
First Middle Last
Patricia McDermott Shirley
SEX **Female**
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife
13. FATHER'S NAME
M. J. McDermott
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No**
16. SOCIAL SECURITY NO. **12 March 1936**
17. INFORMANT
John Arthur Shirley Same as #2 above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Subarachnoid hemorrhage (spontaneous)**
DUE TO (b) **2° to ruptured berry aneurysm.**
DUE TO (c) **12 hrs**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. **19**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. CITY or town (County) (State)

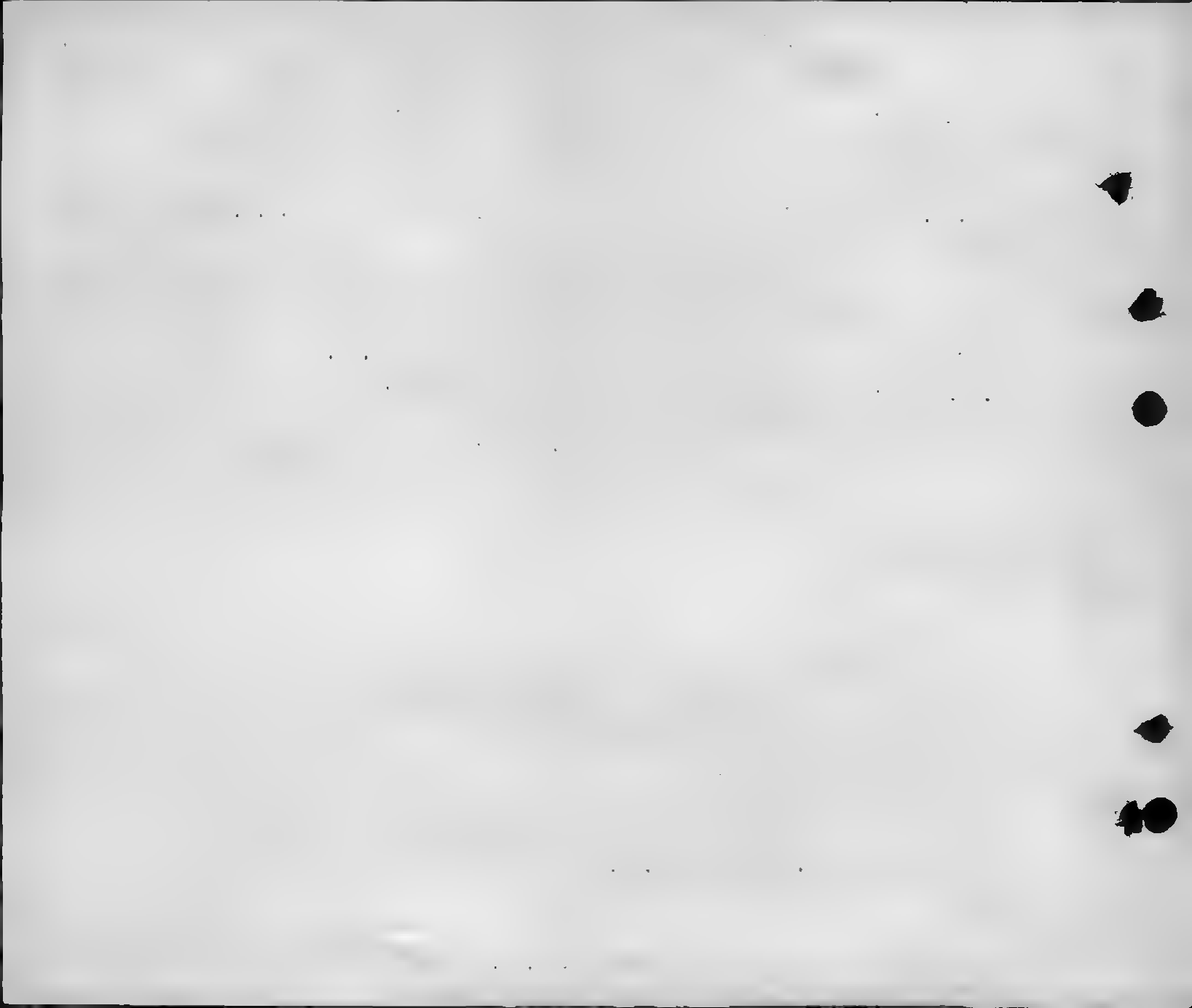
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Frank J. Brochart**
EXAMINER'S NAME (Type) **Frank J. Brochart, M. D.**
22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
22b. DATE THEREOF **Aug. 10, 1961**
22c. NAME OF CEMETERY OR CREMATORY **Arlington National**
22d. LOCATION (City, town, or country) (State)
Arlington Va.

23. FUNERAL DIRECTOR
Timothy Hanlon Funeral Home
ADDRESS
4748 Wisconsin Ave Washington, D. C.

4. DATE OF DEATH
Month Day Year
August 7 19 61
9. AGE (In years IF UNDER 1 YEAR; F UNDER 24 HRS. last birthday) Months Days Hours Min
25 yrs
11. BIRTHPLACE (State or foreign country)
Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?
USA
14. MOTHER'S MAIDEN NAME
Rose Fuller
19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐
DATE SIGNED
August 7, 1961
24a. REC'D BY REGISTRAR
DATE **AUG 10 '61**
24b. REGISTRAR'S SIGNATURE
Charles S. Fenn

Timothy Hanlon F.H. Wm. Fenn



9387

CERTIFICATE OF DEATH

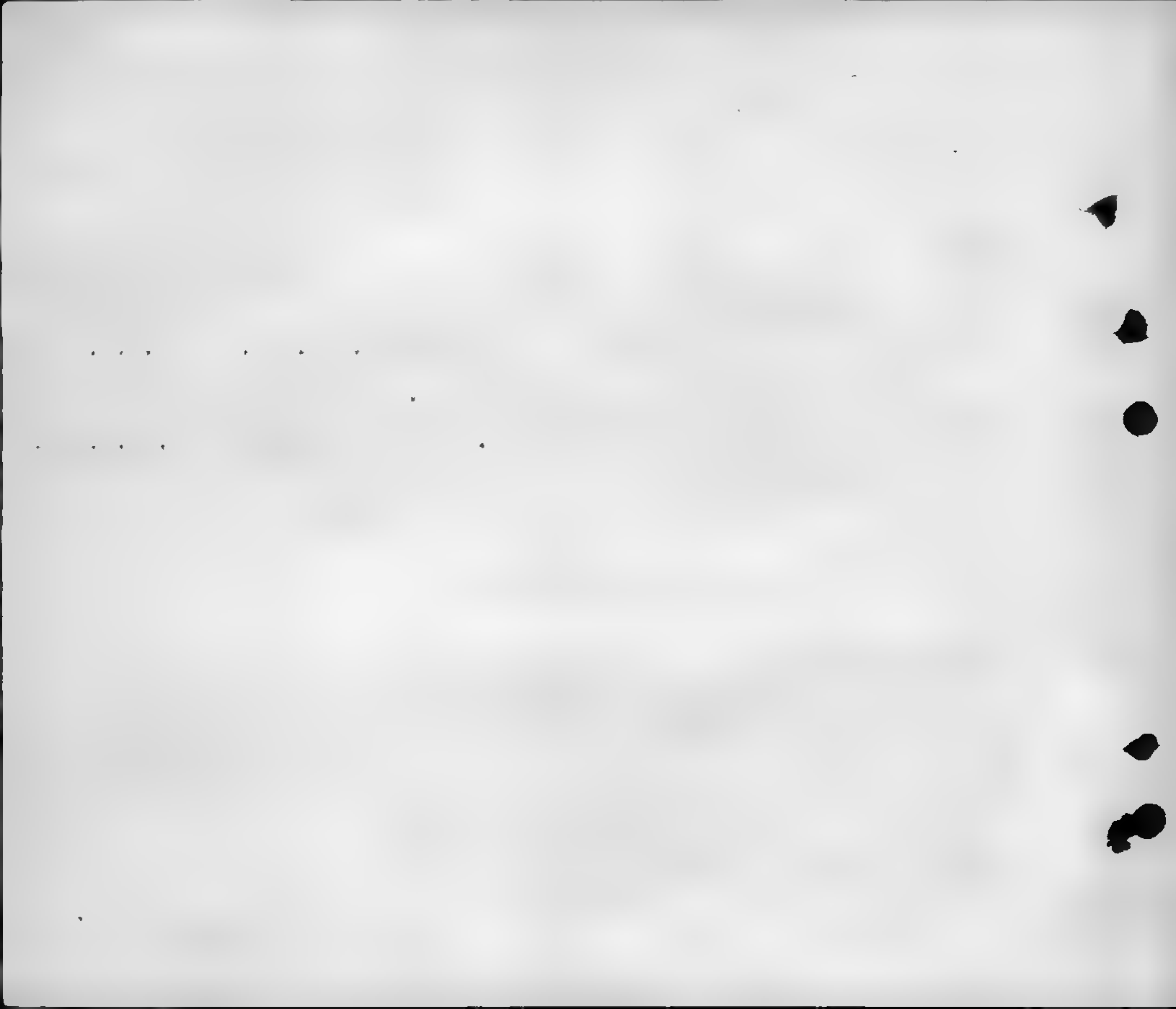
Reg. Dist. No.

09380

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2309 Seibel Drive				e. STREET ADDRESS 2309 Seibel Drive			
3. NAME OF DECEASED (Type or print) First Sadie Middle Agnes Last Smith				4. DATE OF DEATH Month August Day 13th Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6th 1890	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Prince Geo. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard A Windsor,				14. MOTHER'S MAIDEN NAME Roge H. Hutchin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Earl L. Smith 2309 Seibel Dr. S.S. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease DUE TO Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Endometriosis DUE TO (c) Endometriosis						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 12 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from May 27, 1947 to August 13, 1961 , that I last saw the deceased alive on 8-13-61 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph H. Houghlin M.D.			ADDRESS (Street, city or town, state) 934 Edgewood Dr. Silver Spring, Md.		DATE SIGNED 8-13-61		
PHYSICIAN'S NAME (Type) W. W. Chambers, Co.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/61		22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, Co.				24a. AND REGISTRAR Arthur S. Hanks		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL: This certificate is required by the health department and must be filed with the health department within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



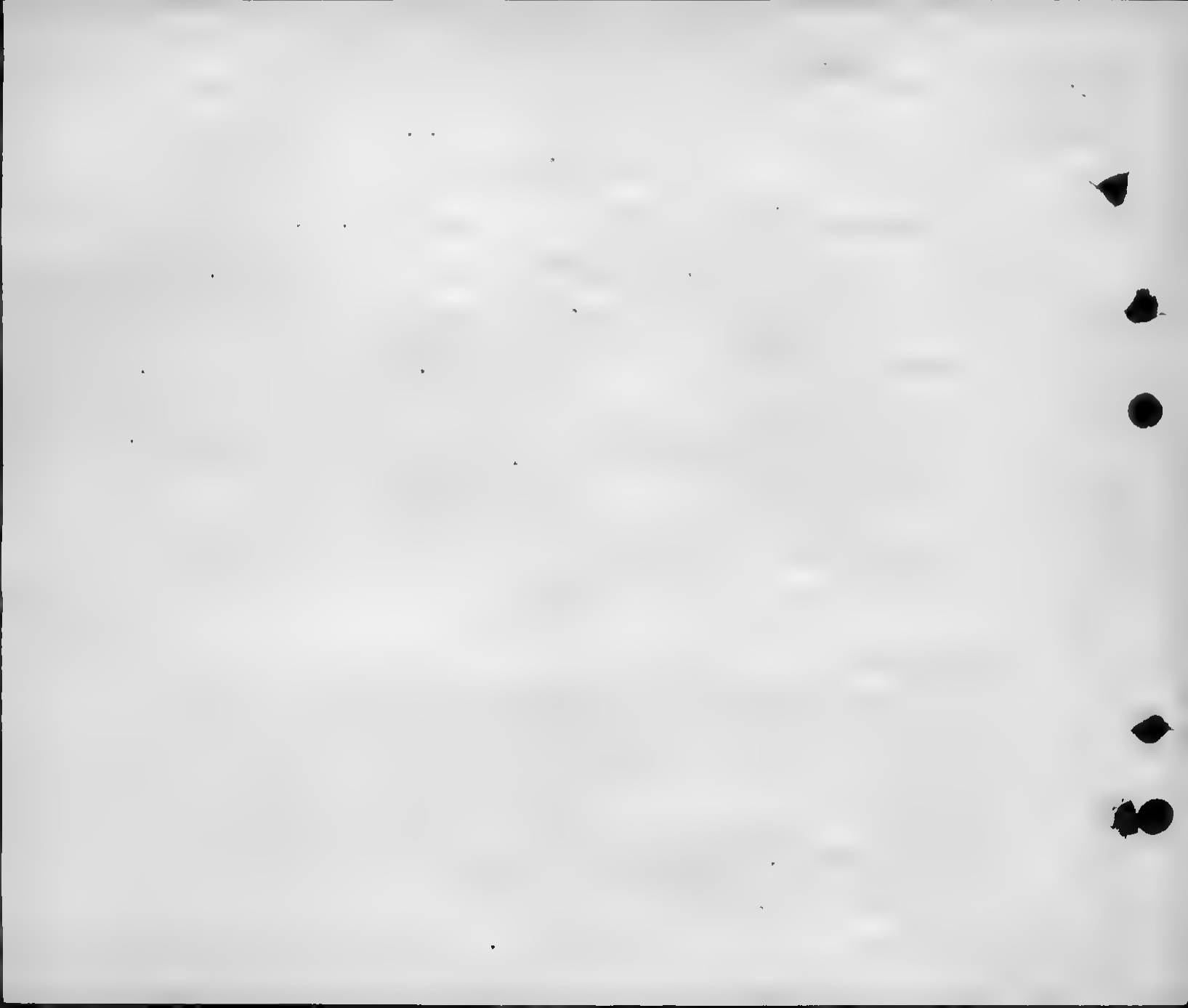
FOR STATE HEALTH DEPT.

9388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09381

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		d. STREET ADDRESS 1301 15th St. N.W.	
3. NAME OF DECEASED (Type or print) LYNN L. SOUTTER		DATE OF DEATH AUG 9 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH July 28 1908	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Business		10b. KIND OF BUSINESS OR INDUSTRY Advertising Business	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDGAR SOUTTER		14. MOTHER'S MARRIED NAME LILLIE LYNN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 057-10-9284	
17. INFORMANT Mrs. Paul Snaver		Address 9506 Mill Stead Dr. Bethesda Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Gastric contents 154X DUE TO (b) Intestinal obstruction DUE TO (c) Carcinoma of rectum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Sudden		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brochart		DATE SIGNED 8-9-61	
EXAMINER'S NAME (Type) Frank J. Brochart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 8-9-61		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Dumfries Cemetery		22d. LOCATION (City, town, or country) (State) Dumfries, Virginia	
23. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR AUG 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	



TO HOSPITAL: A ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

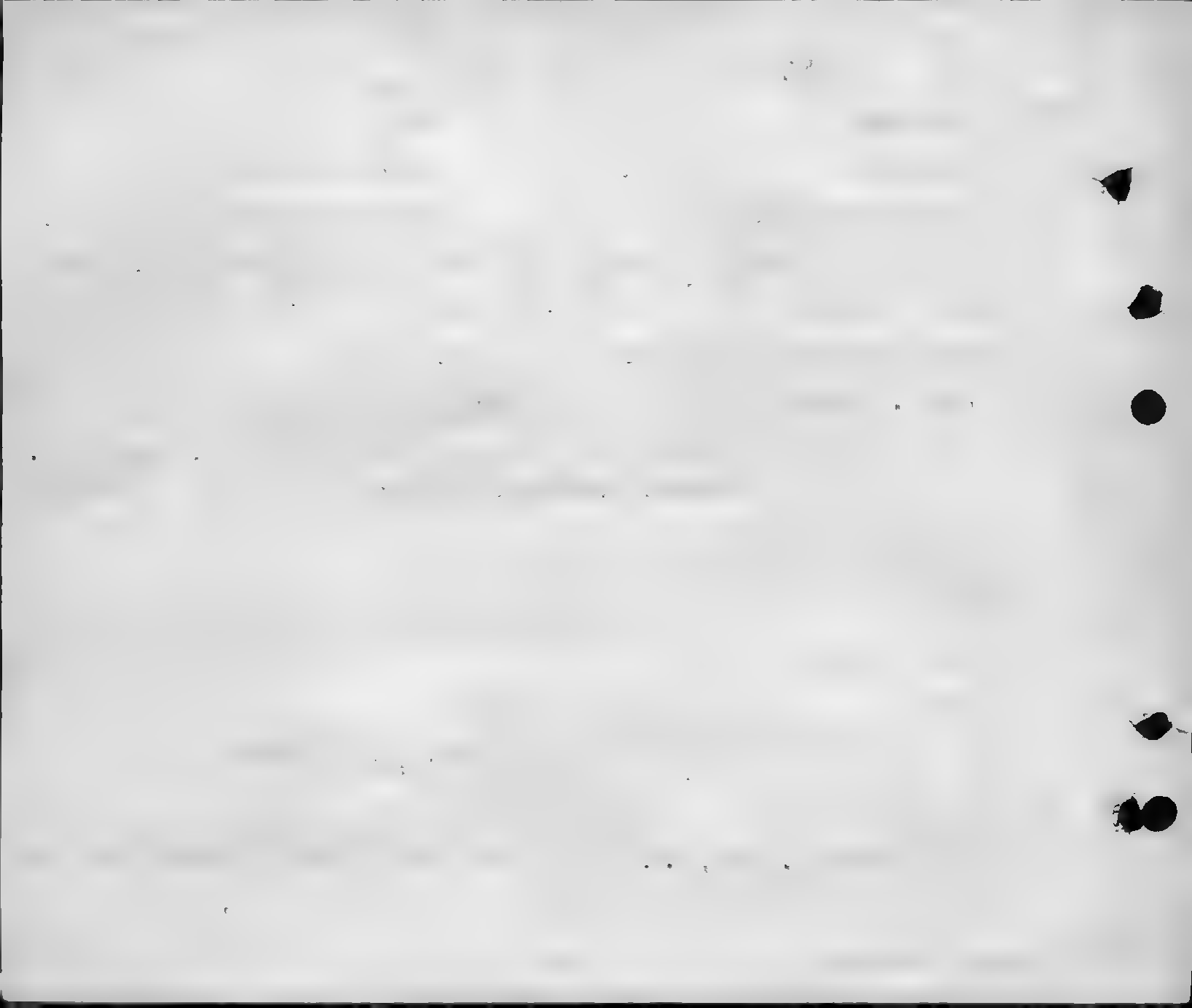
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9389

09382

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Ohio		b. COUNTY Dayton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center		e. STREET ADDRESS 1314 Harvard Boulevard		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM WAITT SPURGEON		4. DATE OF DEATH Month Day Year August 4, 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1898		9. AGE, in years IF UNDER 1 YEAR Last birthday) Months Days Hours Min. 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Circulation Manager		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. PLACE County & State, or foreign country North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John S. Spurgeon	
14. MOTHER'S MAIDEN NAME Carrie Waitt		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Not available		17. INFORMANT Address The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic bronchogenic carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d INJURY OCCURRED While at work Not While at work 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 11, 1961 to August 4, 1961 that (I) (we) last saw the deceased alive on August 4, 1961 and that death occurred at 1:15 PM from the causes and on the date stated above.		22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED 8/4/61		22c. PHYSICIAN'S NAME (Type) ROBERT H. LEVIN, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE THEREOF 18/6/1961		23c. NAME OF CEMETERY OR CREMATORY College Park Cemetery		23d. LOCATION (City, town or county) East Point, Georgia		23e. LOCATION (State) Georgia	
24. FUNERAL DIRECTOR'S SIGNATURE Joe Lawrence		24b. ADDRESS 1756 Park Road		25a. REC'D BY REGISTRAR DATE AUG 8 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Knead		25c. DATE 8/4/61	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9390

CERTIFICATE OF DEATH

09383

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>17</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>17</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u> d. STREET ADDRESS <u>1410 M. ST. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNIE L STEPHENS</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 7 1876</u> 9. AGE (in years, last birthday) <u>84</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Secy US govt.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILBUR STEPHENS</u> 14. MOTHER'S MAIDEN NAME <u>LEAVERTON</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>WINIFRED M HAGER</u> Address <u>340</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal broncho pneumonia</u> (b) <u>Cardiovascular disease</u> (c) <u>4 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>340</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 49</u> to <u>Aug 27</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 27</u> , 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>W. H. Quayle</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>W. H. Quayle M.D.</u>		22b. DATE SIGNED <u>8-27-61</u> 22d. ADDRESS <u>1822 Biltmore St. N.W. Washington DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-28-61</u> 23b. DATE THEREOF <u>Reel</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Washington DC</u>		23d. LOCATION (City, town or county) <u>Washington DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee L. ... of Home ...</u> ADDRESS <u>at Buchanan</u>		25a. REC'D BY REGISTRAR <u>AUG 29 '61</u> 25b. REGISTRAR'S SIGNATURE <u>...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



9391

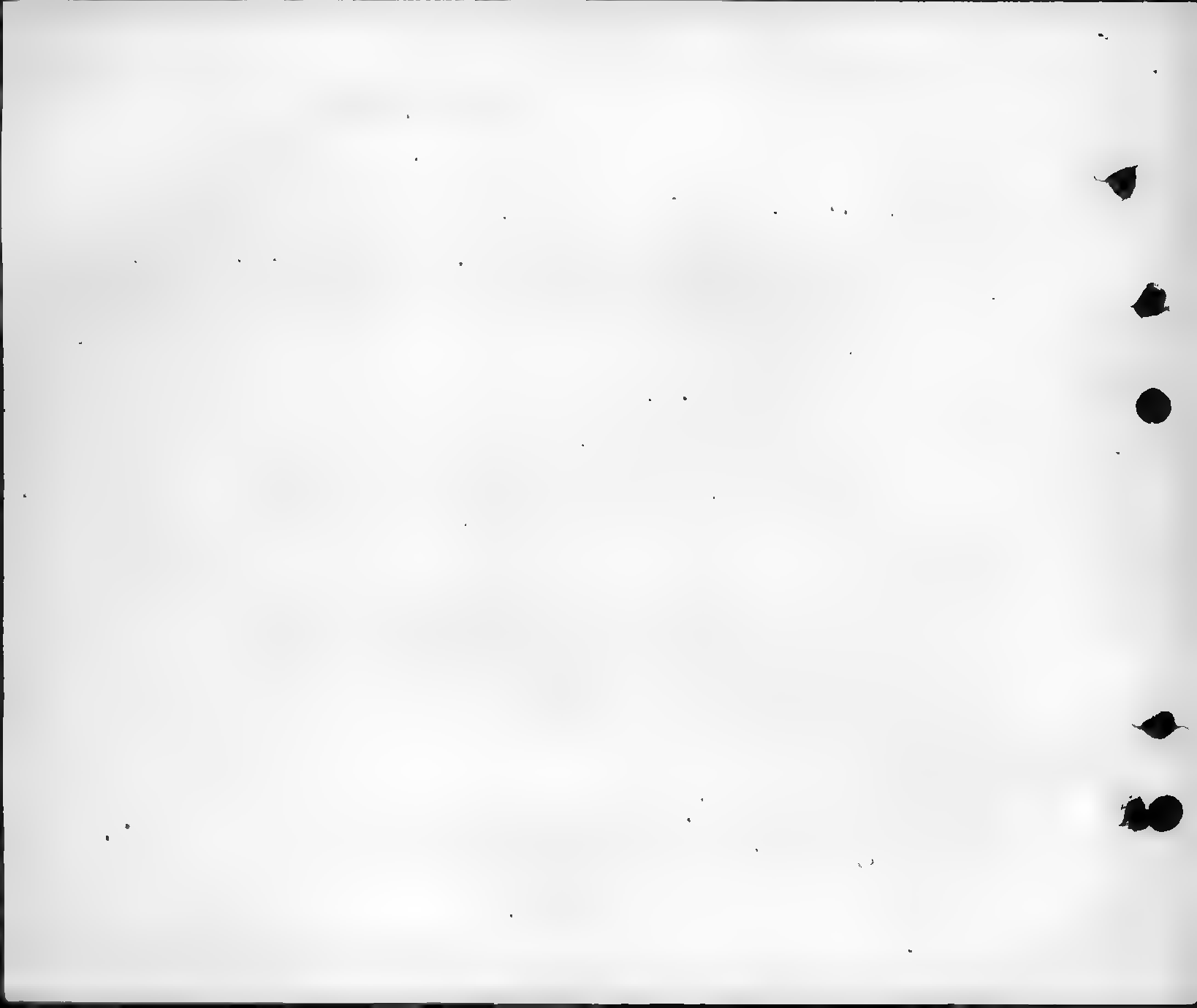
CERTIFICATE OF DEATH

Reg. Dist. No. 119384

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c LENGTH OF STAY IN 1b <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9006 LINTON ST</u>		d STREET ADDRESS <u>19006 LINTON ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LINA STERN</u>		4. DATE OF DEATH Month Day Year <u>AUG. 20 1961</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>SEPT. 29, 1888</u>
9 AGE (In years last birthday) <u>72</u> yrs		10a IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY SITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>ABRAHAM GOLDSCHMIDT</u>		14. MOTHER'S MAIDEN NAME <u>BETTY KLEEBLATT</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16 SOCIAL SECURITY NO <u>088-20-1868</u>	
17 INFORMANT Address <u>MRS LISELOTT FEFERMAN 9006 LINTON ST S.S. Md.</u>			
18 CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery insufficiency</u> 4. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 to 15 minutes</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of right ovary with metastasis</u>		19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I attended the deceased from <u>August 13, 1961</u> to <u>August 20, 1961</u> , that I last saw the deceased alive on <u>August 13, 1961</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Claron H. Traum</u> M.D.		ADDRESS (Street, city or town, state) <u>8237 Georgia Ave. Capital Bldg.</u>	
PHYSICIAN'S NAME (Type) <u>ARON H. TRAUM, MD.</u>		DATE SIGNED <u>S.I. Spg. Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b DATE THEREOF <u>AUG. 21, 1961</u>	22c NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>B. Dugan</u>		24a REC'D BY REGISTRAR ADDRESS <u>3501-14 St NW</u> DATE <u>AUG 24 61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert L. P. P.</u>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

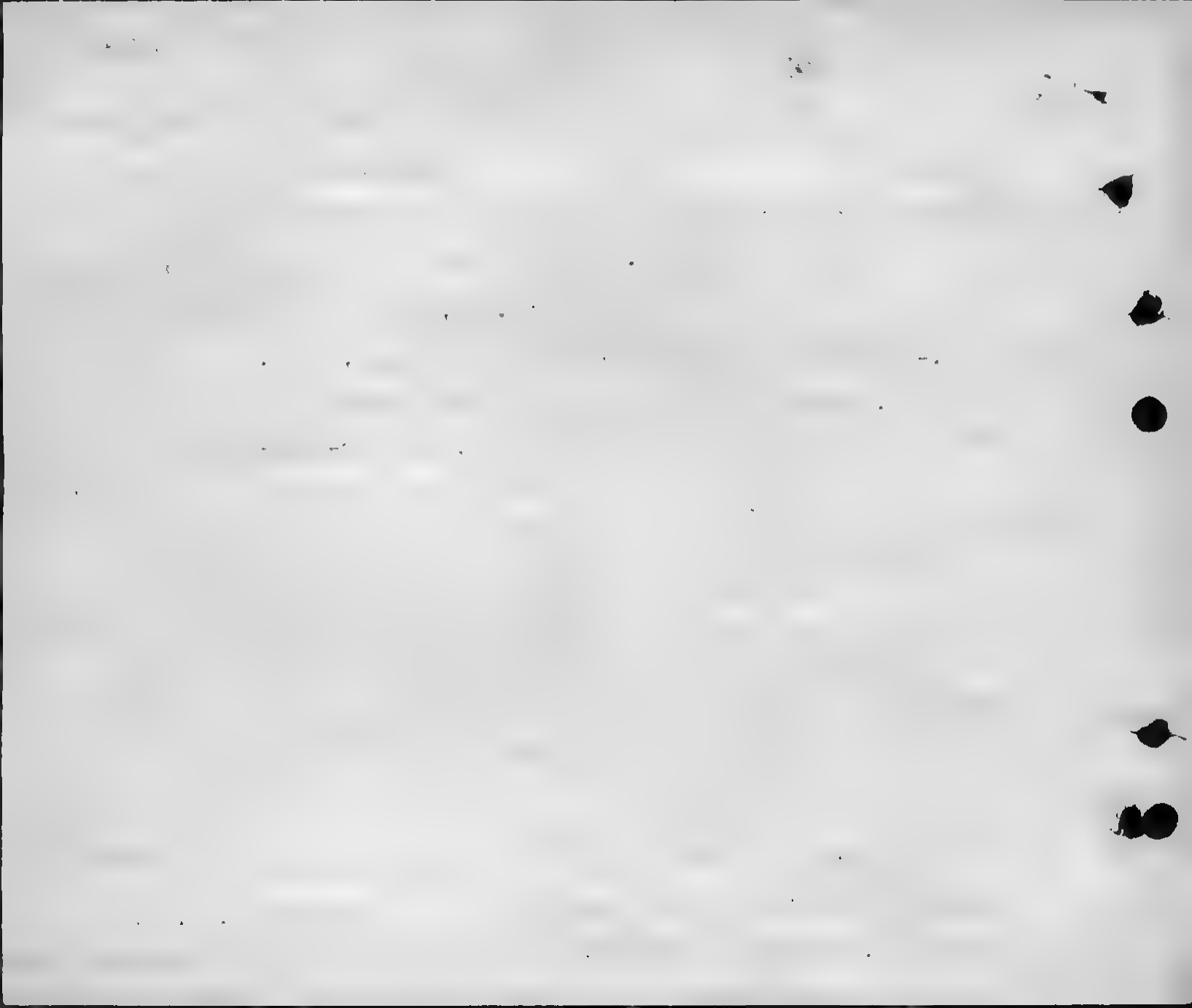
VR A15 (4)
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
9392			
15385			
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5300 Westbard Avenue		e. STREET ADDRESS 5300 Westbard Avenue	
3. NAME OF DECEASED (Type or print) HENRY J. STERZER		4. DATE OF DEATH August 1, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27, 1890	
9. AGE (In years, if under 1 year, last birthday) 70 yrs 11 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Wholesaler Gas Station	
11. FATHER'S NAME John N. Sterzer		12. CITIZEN OF WHAT COUNTRY? USA	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		14. MOTHER'S MAIDEN NAME Alma Rupel	
15. SOCIAL SECURITY NO None		16. INFORMANT Elsie W. Sterzer-Wife-same 2d	
17. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 1-20 DUE TO (b) Bronchopneumonia connected w/ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Chronic Pulmonary Emphysema		INTERVAL BETWEEN ONSET AND DEATH 3 YRS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Bronchopneumonia Chronic Pulmonary Emphysema		19. WAS AUTOPSY PERFORMED? YES	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item 17) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that (I) (this hospital) attended the deceased from July 29, 1961 to August 1, 1961 , that (I) (we) last saw the deceased alive on July 29, 1961 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Henry C. Scruggs		22b. DATE SIGNED August 1, 1961	
22c. PHYSICIAN'S NAME (Type, HENRY C. SCRUGGS)		22d. ADDRESS 7720 LANSBORN AVE BETHESDA MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/4/61	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR AUG 4 '61	
25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey		25c. REGISTRAR'S SIGNATURE Robert A. Pumphrey	



CERTIFICATE OF DEATH

09386

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8001 Barron Ave.</u>		d. STREET ADDRESS <u>8001 Barron Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>MORRIS</u> First <u>L</u> Middle <u>STIER</u> Last		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1874</u>
9. AGE in years <u>87</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John N. Stier</u>		14. MOTHER'S MAIDEN NAME <u>Christina Skidley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Howard Stier</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>many years</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 19, 58</u> to <u>Aug 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 24, 1961</u> , and that death occurred at <u>6:25 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Doris R. Coleman M.D.</u>		22b. DATE SIGNED <u>8/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d. ADDRESS <u>7335 Ridge Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-28-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>McKenzie</u>		23d. LOCATION (City, town or county) (State) <u>Providence, Howard Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 29 '61</u>	
ADDRESS <u>Clydeville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur H. Haight</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9394

CERTIFICATE OF DEATH

Item 2 Film G295 8/22/61 ink

09387

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN 1b

174 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF DECEASED (Type or print)

First

Middle

Allen

5. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-22-25

4. DATE OF DEATH

Month

Day

Year

August

20

1961

9. AGE (In years last birthday)

35 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Armed Forces

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Navy

11. BIRTHPLACE (County & State, or foreign country)

W. Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Fred D. Stissel

14. MOTHER'S M.A.DEN NAME

Sadie Chafin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes WW II

16. SOCIAL SECURITY NO

18236-36-9095

17. INFORMANT

Hospital Records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

PULMONARY METASTASES

DUETO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

RHABDOMYO SARCOMA LEFT THIGH

DUETO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

RADIATION PNEUMONITIS

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (1) (this hospital) attended the deceased from February 27, 1961, to August 20, 1961, that (2) (we) last saw the deceased alive on August 20, 1961, and that death occurred at 11:45, from the causes and on the date stated above.

22a. SIGNATURE

W. J. Mullins Jr.

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED

21 August 1961

22c. PHYSICIAN'S NAME (Type)

W. J. MULLINS, JR. LT MC USN

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

Burial - Shipment 22 Aug 1961 Family Cemetery

New Town

W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE

W.W. Chambers, 1400 Chapin St. Washington, D.C.

25a. REC'D BY REGISTRAR

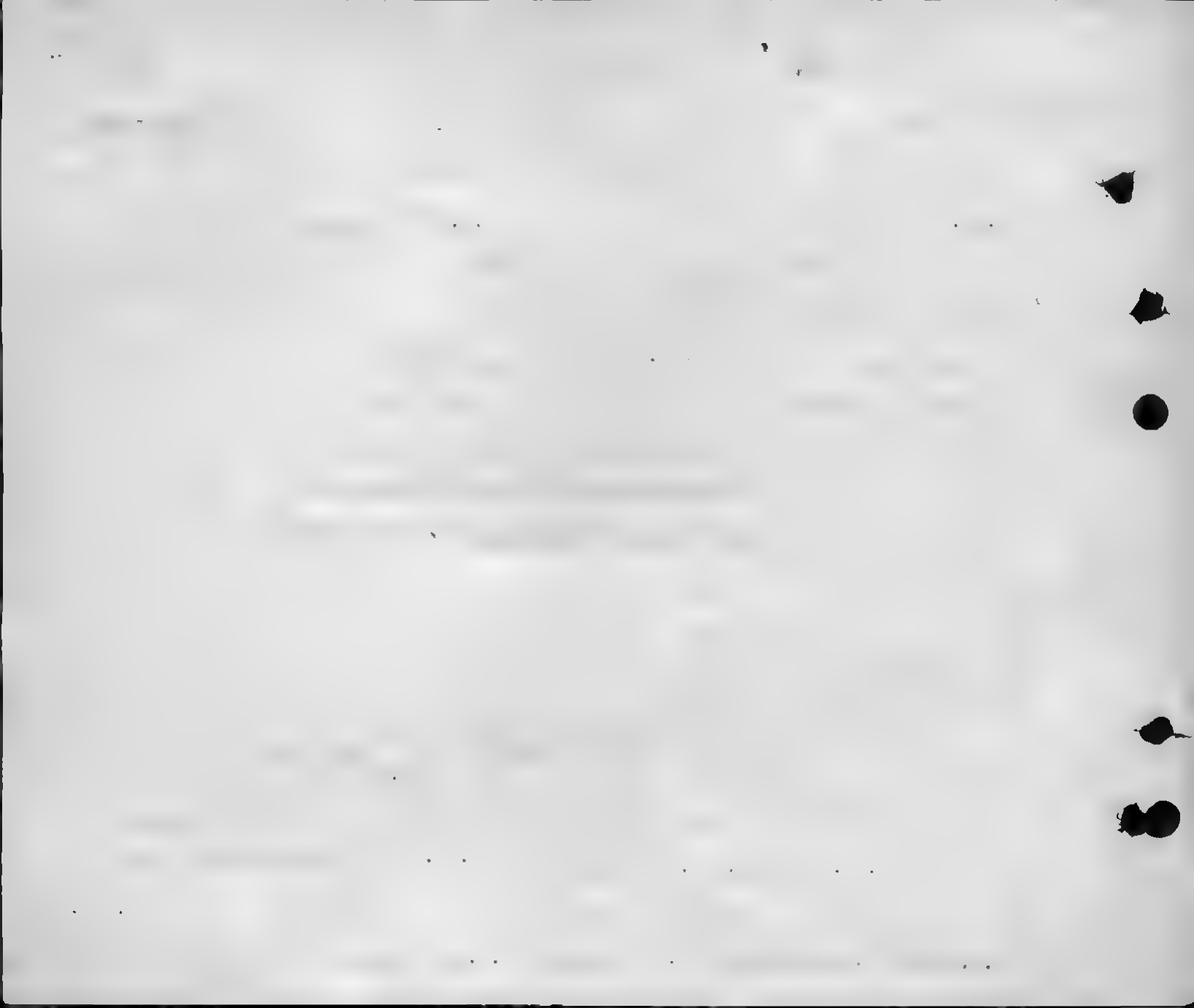
25b. REGISTRAR'S SIGNATURE

DATE AUG 24 '61

Arthur L. Kinner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
15M 9/60



9395

CERTIFICATE OF DEATH

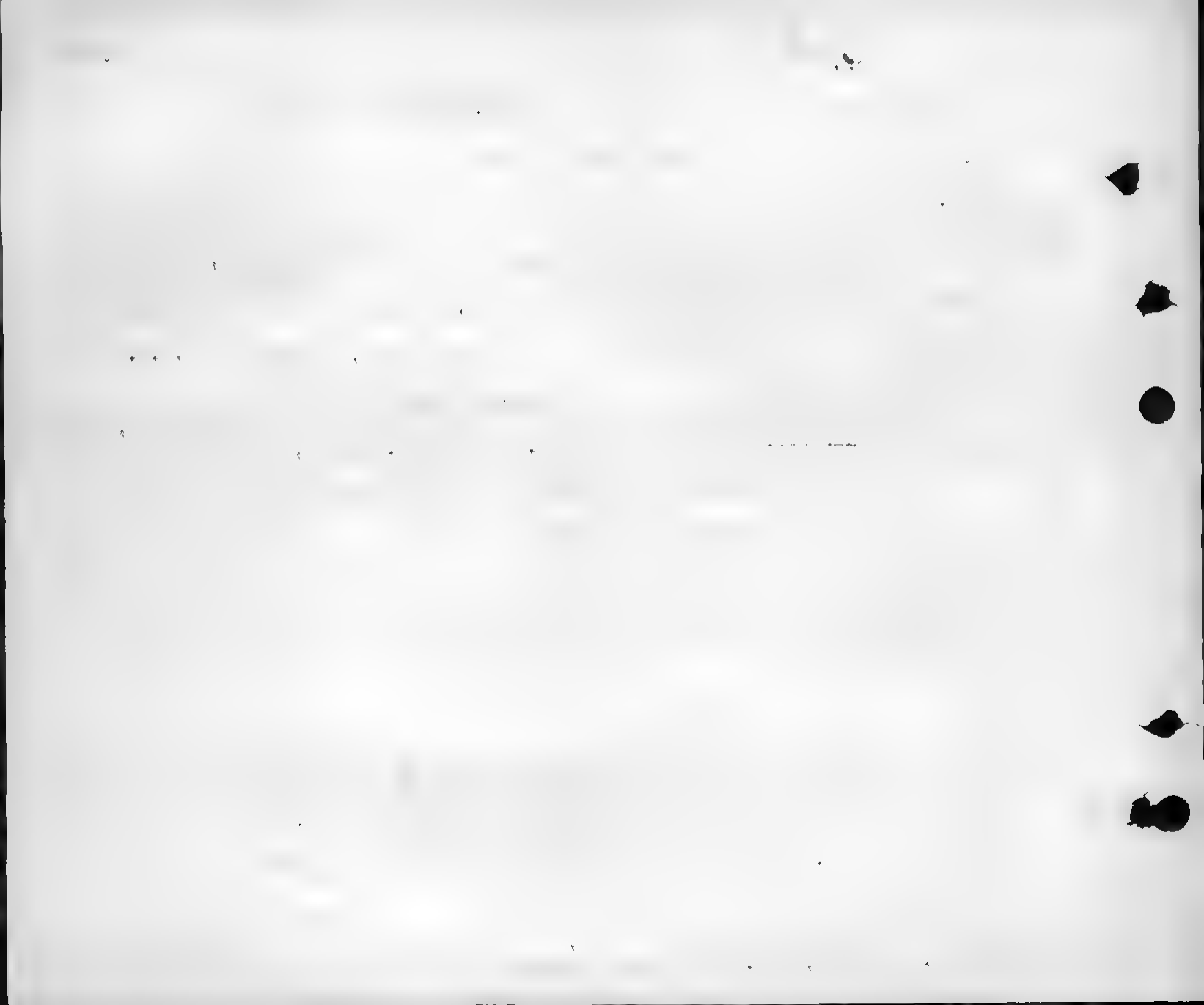
Reg. Dist. No. 09388

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MONTANA b. COUNTY NE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b five weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS EX -	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lou Middle Stringfellow Last		4. DATE OF DEATH Month August Day 3 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1871
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Three Rivers, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Peek		14. MOTHER'S MAIDEN NAME Almira Dimick	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. ADDRESS Silver Spring, Maryland		18. ADDRESS Mrs. Virginia L. Bruner, 1108 Highland Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5-10 yrs ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) metastatic Carcinoma of lungs (primary site unknown)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 58 to 3 Aug 1961 , that I last saw the deceased alive on 2 Aug 1961 , and that death occurred at 4:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud M.D.		ADDRESS (Street, city or town, state) 9086 Colanville Rd Silver Spring Md	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		DATE SIGNED 8/3/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial/Transit 8/7/61		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Glendale California	
23. FUNERAL DIRECTOR'S NAME AND ADDRESS Warner E. Pumphrey, Inc. 8434 Georgia Avenue		24a. REC'D BY REGISTRAR DATE AUG 7 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

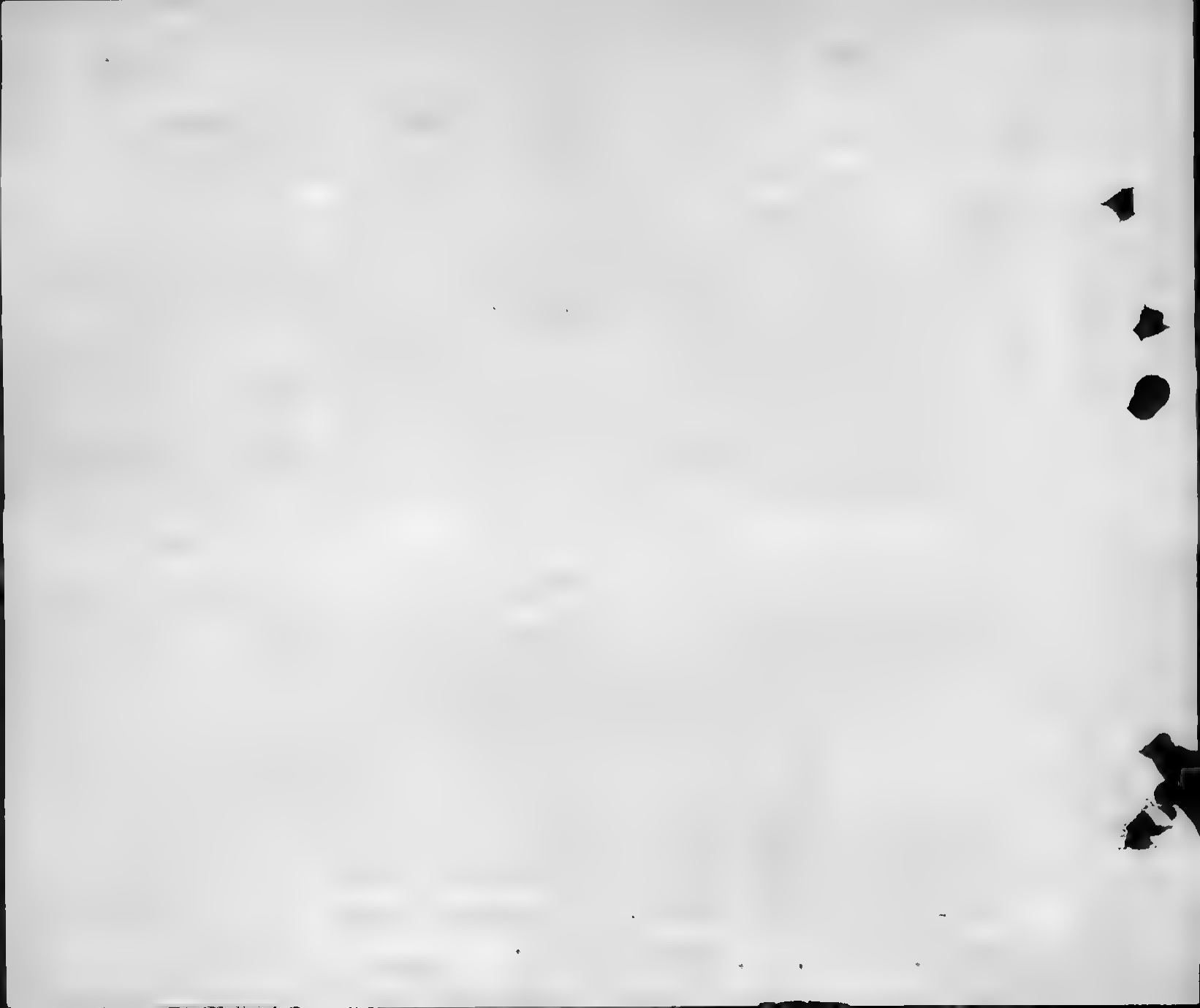
9395 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09389

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) At Takoma Park c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San. & Hosp.		2. USUAL RESIDENCE (Where deceased lived, first full; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10407 Berry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Tyler Stultz		4. DATE OF DEATH Month Aug Day 3 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-11-11
9. AGE (In years last birthday) 50 1/2		10. IF UNDER 1 YEAR Months 5 Days 12	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender & Care taker.		10b. KIND OF BUSINESS OR INDUSTRY N.C.	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stultz		14. MOTHER'S MAIDEN NAME Cora Wards Ward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number of service) NO		16. SOCIAL SECURITY NO. 238-14-2466	
17. INFORMANT Mr. Tyler F. Stultz		Address 1602 Gridley La S.S. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO CORONARY SCLEROSIS AND OCCLUSION, OLD DUE TO ASPIRATION OF GASTRIC CONTENT DUE TO DIED IN AUTOMOBILE WHILE DRIVING PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIED IN AUTOMOBILE WHILE DRIVING		INTERVAL BETWEEN ONSET AND DEATH HOURS MINUTES	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		DATE SIGNED 8-3-61	
EXAMINER'S NAME (Type) FRANK J. BROSCHE		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 8/5/61		22b. DATE THEREOF 8-5-61	
22c. NAME OF CEMETERY OR CREMATORY Thursjay Church Cemetery		22d. LOCATION (City, town, or country) Carolina	
23. FUNERAL DIRECTOR Raymond A. Ziska		24a. REC'D BY REGISTRAR Aug 9 '61	
24b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc.		24c. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc.	

VS. A15ME
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours of death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that death certificates be completed by the attending physician and completely filled in by the funeral director. Page 1 and 2 should be removed and placed in the State Department of Health prior to burial, cremation, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Their removal, and in any event, within 72 hours after death.

M

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9397

09390

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitorium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9023 Flower Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Lucemma Forest Tallman</u>		4. DATE OF DEATH <u>8 - 31 - 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 - 15 - 77</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>							
13. FATHER'S NAME <u>Marshall G. Drake</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth McQuain</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>							
16. SOCIAL SECURITY NO. <u> </u>												17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause, and name for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Chronic Hypertension + Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET OF DEATH <u>3/1/61</u> <u>21:00</u> <u>7/1/61</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>8/30/61</u> to <u>8/30/61</u> , that (I) (we) last saw the deceased alive on <u>8/30/61</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Howard I. Moore</u>												22b. ADDRESS <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u> </u>												22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept 4 - 61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge</u>				23d. LOCATION (City, town or county) (State) <u>Rockwood. Tenn.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>												25a. REC'D BY REGISTRAR <u>SEP 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	



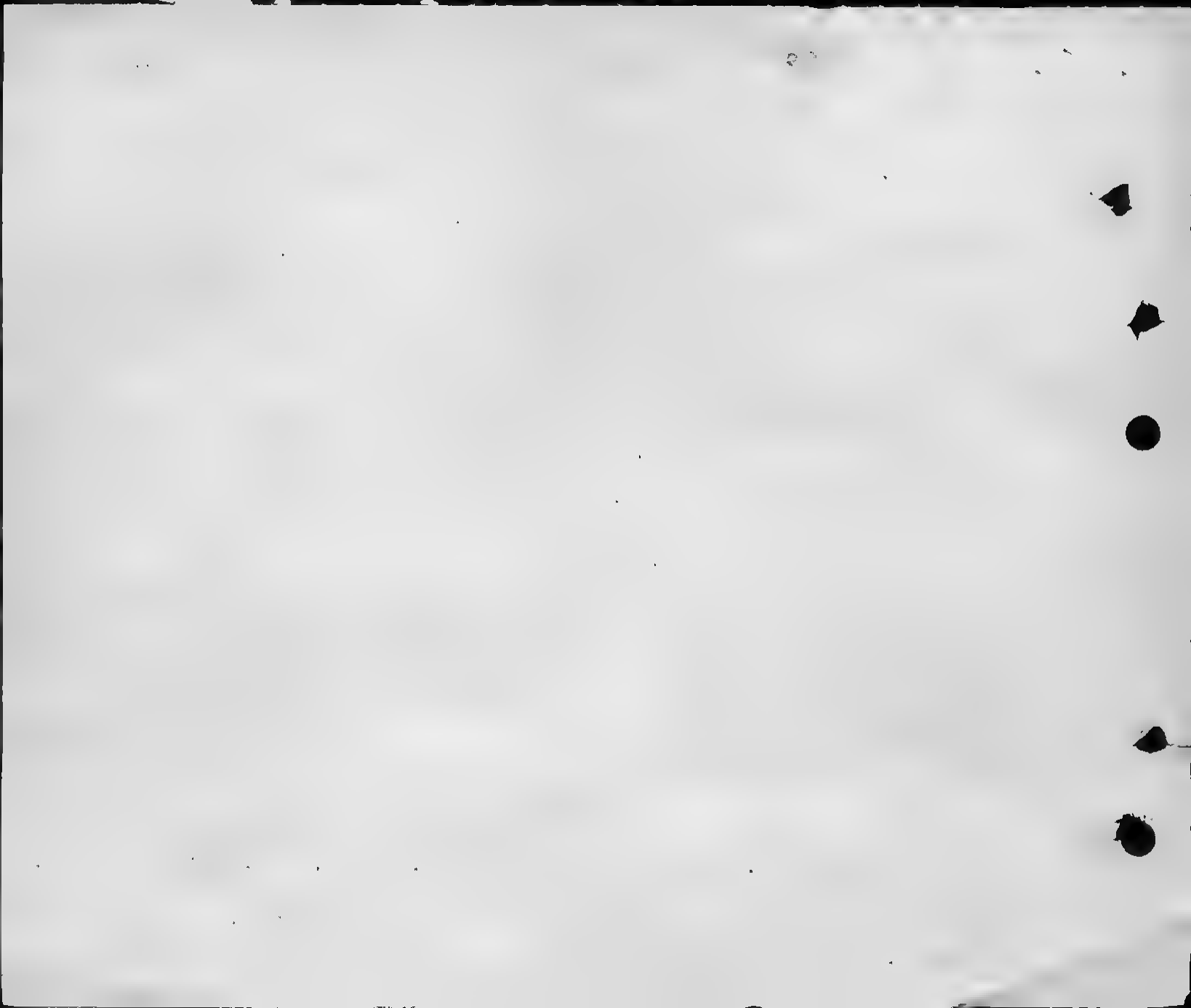
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9398 CERTIFICATE OF DEATH 09391

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Gaithersburg</u>	
c. LENGTH OF STAY IN IT <u>6 days</u>		d. STREET ADDRESS <u>425 N. Frederick Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>			
3. NAME OF DECEASED (Type or print) <u>Leon Albert Tarbox</u>		4. DATE OF DEATH <u>August 31 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-1899</u>
9. AGE (In years last birthday) <u>62 yrs</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Mn.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AEC</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Warren, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip A Tarbox Sheridan</u>		14. MOTHER'S MAIDEN NAME <u>Grace Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMATION <u>Hospital records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One year</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OBSTRUCTIVE PULMONARY EMPHYSEMA</u>		20 YEARS	
(c) <u>ARTERIO-SCLEROTIC HEART DISEASE</u>		20 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC RENAL INSUFFICIENCY - PEPTIC ULCER</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>s.m.</u> <u>p.m.</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7:10 A.M.</u> 19 <u>59</u> to <u>SEPT. 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 31, 1961</u> , and that death occurred at <u>12:57 P.M.</u> from the causes and on the date stated above.			
22. SIGNATURE <u>Gordon S. Rosenberg</u>		22b. DATE SIGNED <u>Aug 31, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberg</u>		22d. ADDRESS <u>310 W. Montg. Ave. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/2/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Johnstown, Pennsylvania</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 5 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

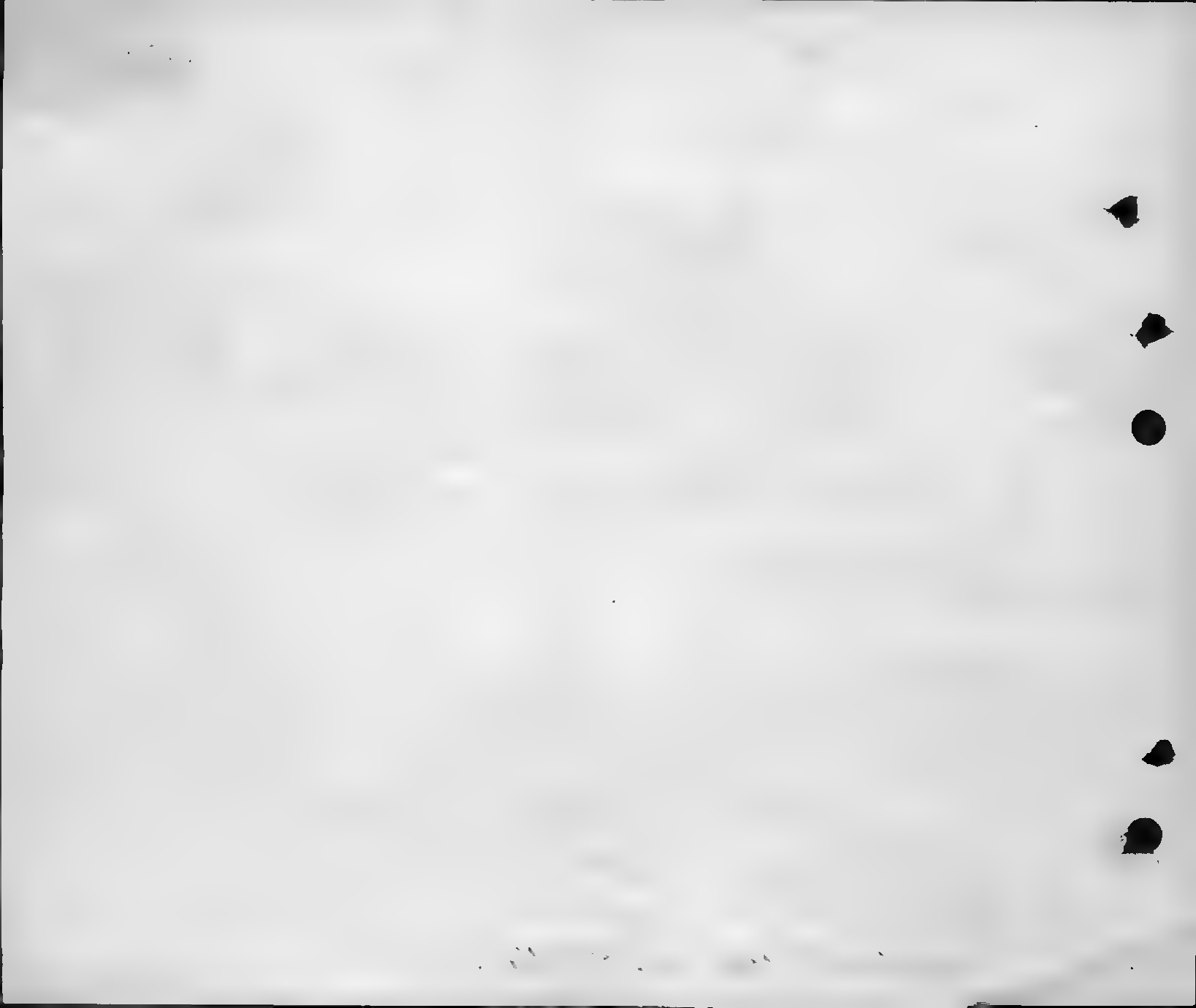
9399

CERTIFICATE OF DEATH

09392

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>	
c. LENGTH OF STAY IN 1b <u>4 days 12 hrs.</u>		d. STREET ADDRESS <u>12921 Columbia Pike</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Alfred R. Taylor</u>		4. DATE OF DEATH Last <u>8</u> Month <u>10</u> Day <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-1890</u>
9. AGE (in years last birthday) <u>70</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Examiner</u>	11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Hannis Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Leonora Le Baron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMATION <u>Hospital Record</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c))			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>570.5</u> DUE TO <u>Intestinal Obstruction</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastric Ulcers, Congestive Failure with Fibrillation</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1961</u> to <u>Aug 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 9 1961</u> , and that death occurred at <u>1:48 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert F. Hare</u>		22b. DATE SIGNED <u>Aug 10, 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Hare MD.</u>		22d. ADDRESS <u>2600 Carroll Ave. T.P. Md.</u>	
23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11 AUG. 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BLADENSBURG, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Terrelli Funeral Home</u>		25a. REC'D BY REGISTRAR <u>AUG 11 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9400

09393

1 PLACE OF DEATH a. COUNTY <u>Suburban Hospital</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>42 days 1 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Springridge Rd.</u>			
3 NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Taylor</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1961</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/8/01</u>	
9. AGE (In years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11 BIRTHPLACE (State or foreign country) <u>Wash., D. C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Boyd Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Marion Lilley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>578-18-1759</u>		17 INFORMANT <u>Gladys Taylor, wife</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Metastasis</u> DUE TO <u>Chronic Carcinoma of Right Lung Cavity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>20 Aug 1961</u> , that (I) (we) last saw the deceased alive on <u>20 Aug 1961</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>William S. Murphy</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>8/20/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>William S. Murphy</u>		22d. ADDRESS <u>615 W. Mont. Ave., Rockville, Md.</u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Potomac, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Throckmorton</u>	

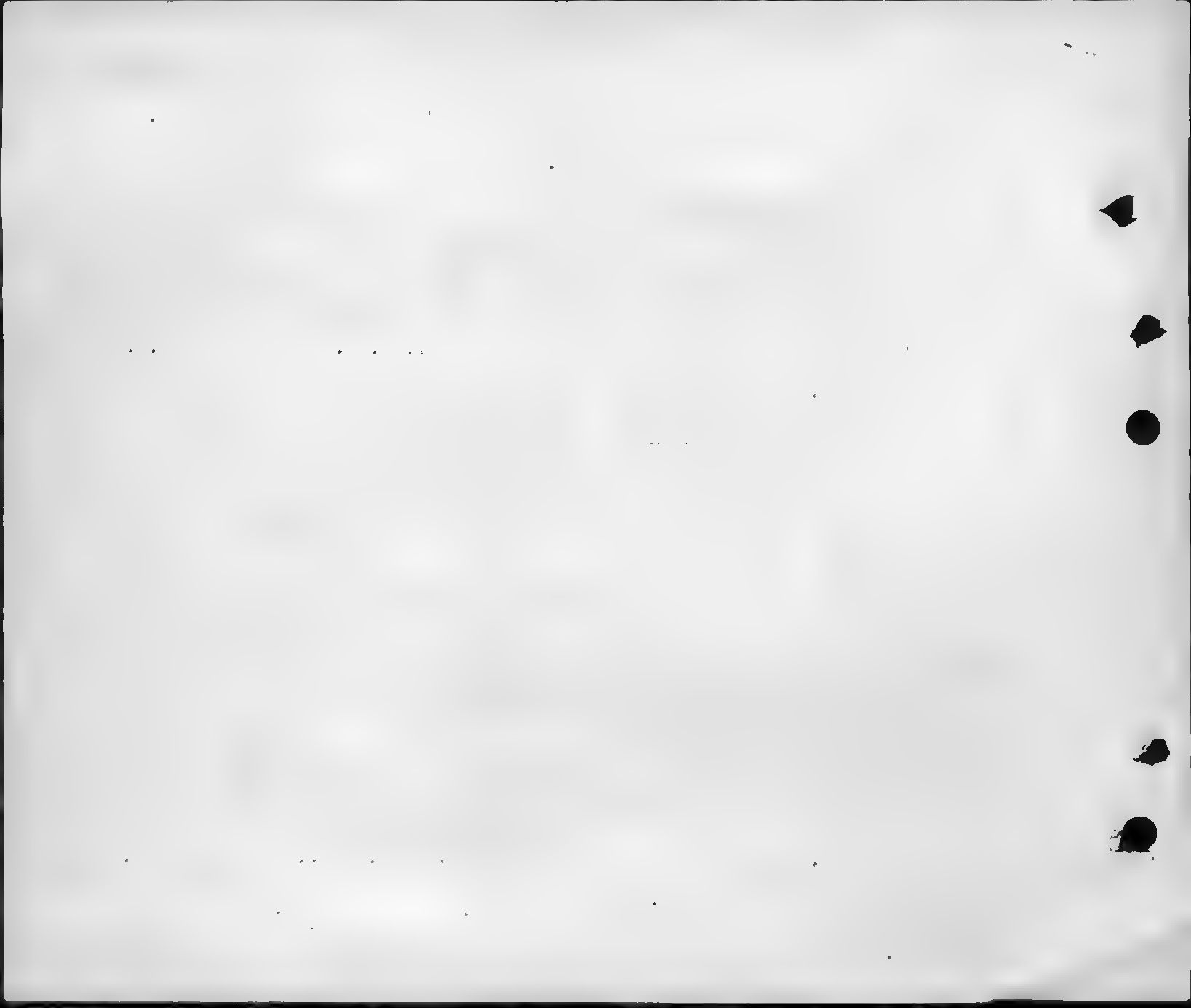
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

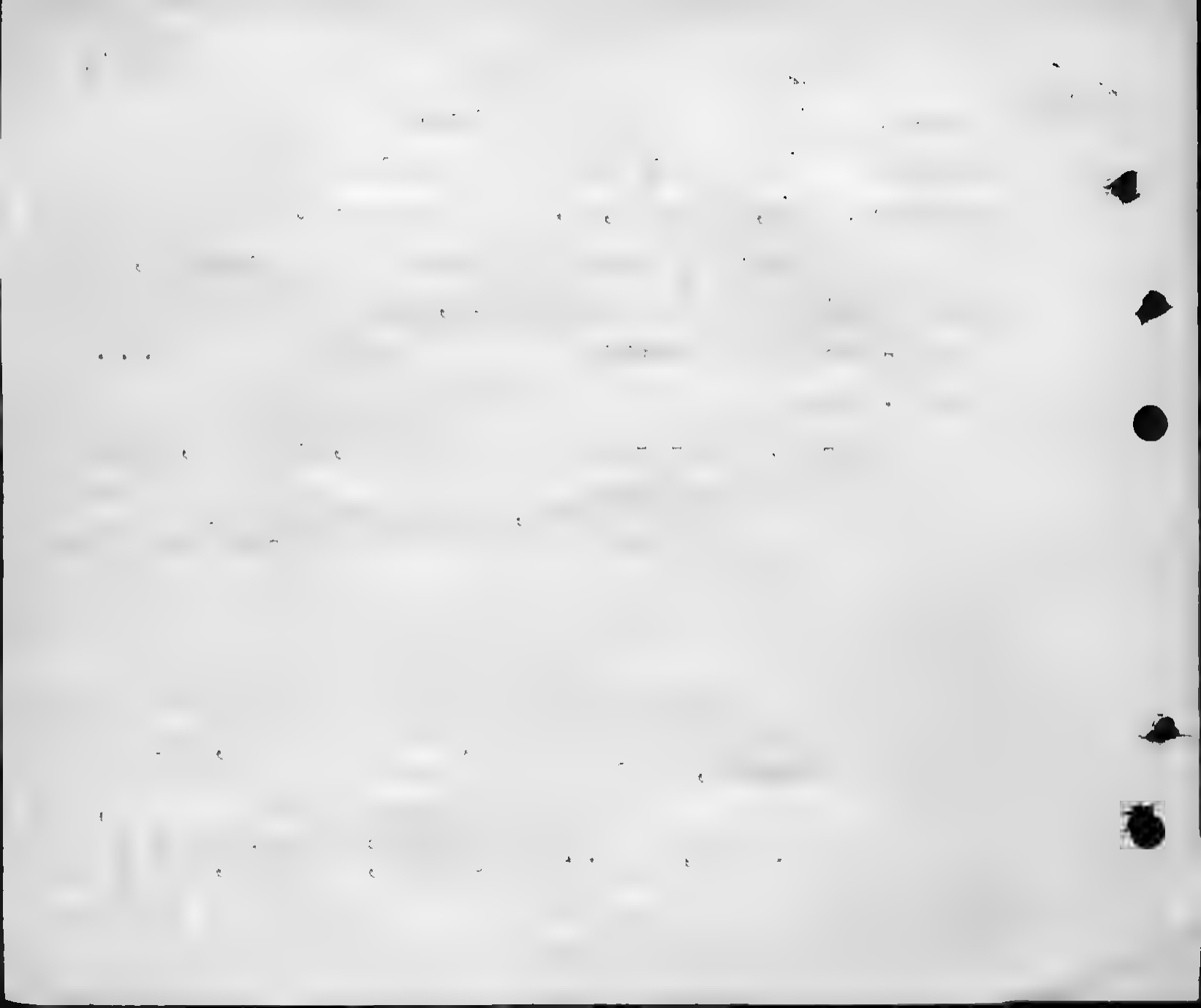
9401

09394

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN (b) <u>31 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Minnesota</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Paul</u> d. STREET ADDRESS <u>1758 Agate Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Robert Rhys Thomsen</u>		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>19 61</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 6, 1934</u>									
9. AGE (In years, last birthday) <u>27</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Producer-Director</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Television</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Edward J. Thomsen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Toy</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 1956 - 1959</u>		16. SOCIAL SECURITY NO. <u>480-38-4494</u>									
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO (b) <u>Anaplastic carcinoma, primary unknown, with bone marrow, hepatic, retroperitoneal & gastro-intestinal metastases</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____									
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>July 6, 1961</u> to <u>August 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 6, 1961</u> , and that death occurred at <u>8:15 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Thorne S. Winter, III</u> M.D.		22b. DATE SIGNED <u>8/7/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>THORNE S. WINTER, III, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		23b. DATE THEREOF <u>8/8/61</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town or county) <u>Iowa</u> (State) _____									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>August 10 '61</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		25c. ADDRESS <u>Bethesda, Maryland</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

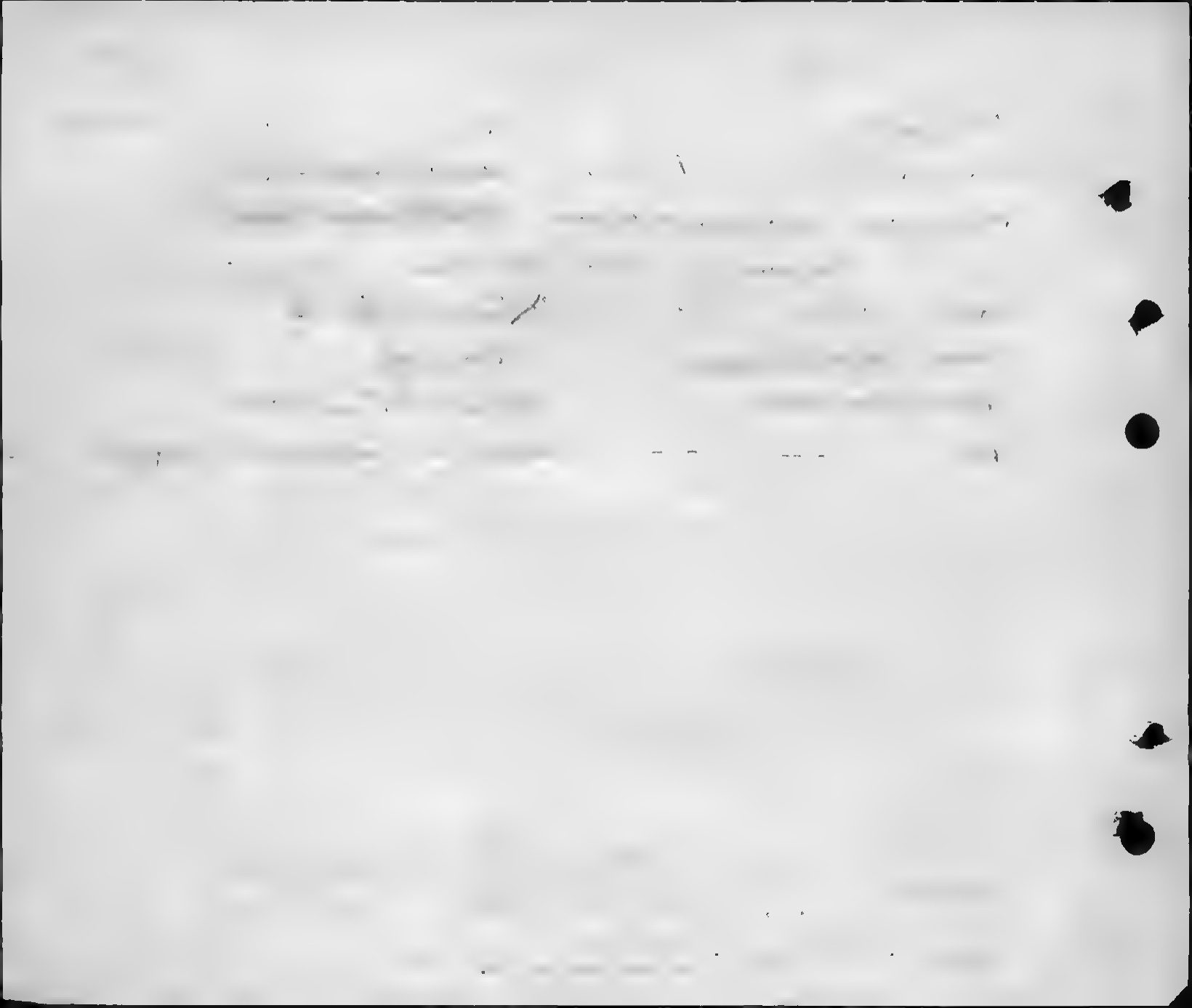
CERTIFICATE OF DEATH

9402

09395

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>1929 Laguna Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond White Van Horn</u>		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25, 1891</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Security Guard</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John A. Van Horn</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Tucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-05-4056</u>	
17. INFORMANT <u>Washingt. Sanitarium + Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma with metastases to bone & pathological fractures of right femur.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>pathological fractures of right femur.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Interval between onset and death 3 months</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... August 1960, to Aug 5, 1961, that (I) (we) last saw the deceased alive on... Aug 5, 1961, and that death occurred at 11 PM, from the causes and on the date stated above			
22a. SIGNATURE <u>Boris Rabkin</u>		22b. DATE SIGNED <u>8/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		22d. ADDRESS <u>1019 University Blvd, East Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE THEREOF <u>Aug. 9, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Varner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

VR A15 (4)
15M 9/60



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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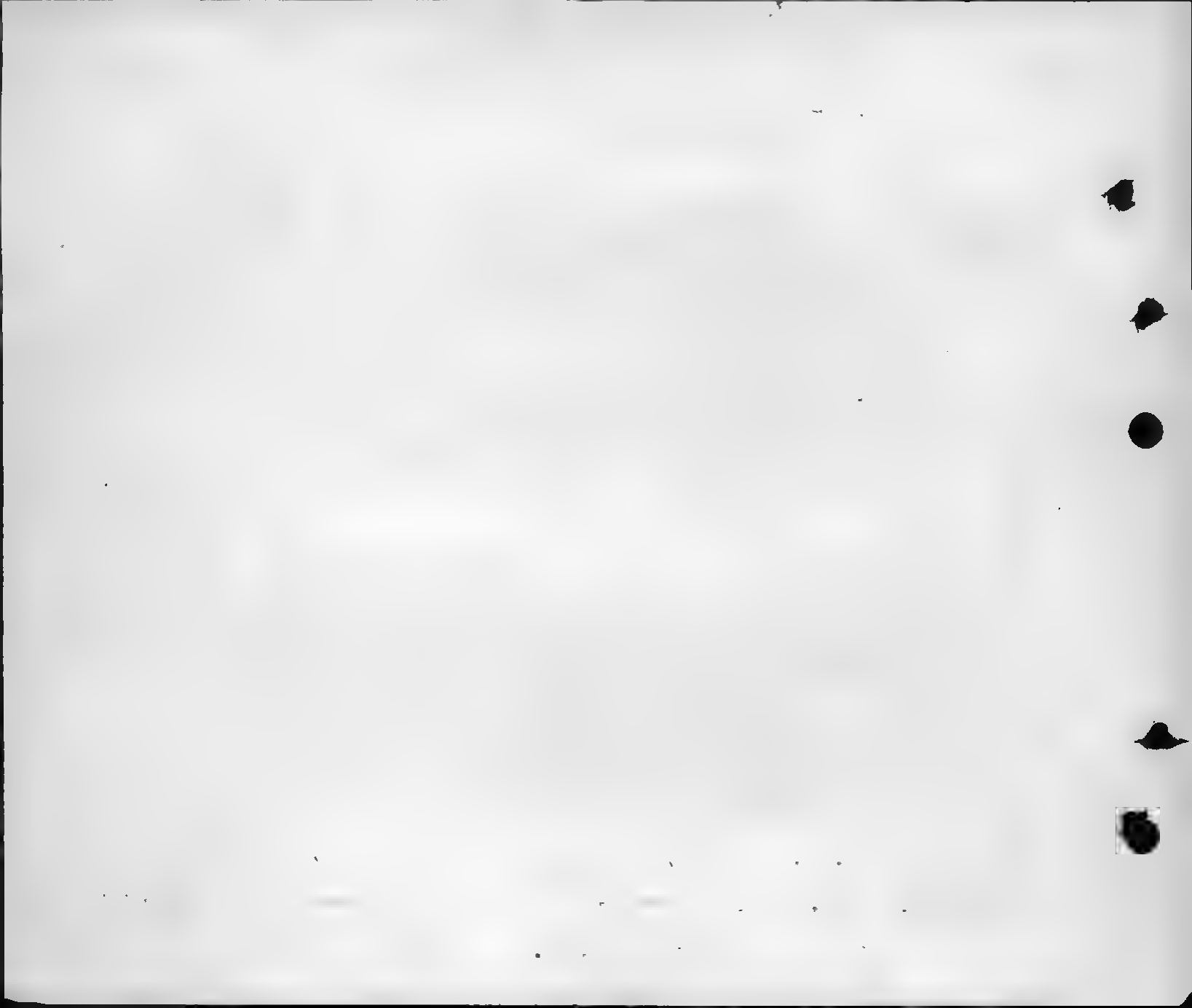
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09396

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		d. STREET ADDRESS Carrs Mill Road	
3. NAME OF DECEASED (Type or print) First Dwayne Middle Carl Last Viers		4. DATE OF DEATH Month August Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/60
9. AGE (in years lost birthday) 10 yrs		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min	IF UNDER 24 HRS Hours 10 Min 10
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Tivis C. Viers	
14. MOTHER'S MAIDEN NAME Agnes Rasnick		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO —		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 DUE TO Congestive heart failure & pul. edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Toxemia (c) Enteritis		INTERVAL BETWEEN ONSET AND DEATH 24 hours 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ascariasis, anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/27 1961 to 8/27 1961 , that (I) last saw the deceased alive on 8/27 1961 , and that death occurred at 4:40 A. from the causes and on the date stated above			
22a. SIGNATURE G. F. Meadors, M.D.		22b. DATE SIGNED 8/27/61	
22c. PHYSICIAN'S NAME (Type) G. F. Meadors, M.D.		22d. ADDRESS Damascus, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Aug. 27 1961	
23c. NAME OF CEMETERY OR CREMATORY Prather		23d. LOCATION (City, town, or county) (State) Prather Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.	
25a. REC'D BY REGISTRAR SEP 1 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9404

09397

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK ANTONIO WADE</u>				4. DATE OF DEATH Month Day Year <u>August 6 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1961</u>		9. AGE (in years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius Wallace Wade</u>				14. MOTHER'S MAIDEN NAME <u>Izetta Bruce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>C. Wallace Wade (father)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u>							
47- DUE TO (b) <u>Acute bronchitis</u>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>pneumonia</u>							
<u>Possible virus infection</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(supplemental pathological report may be sent later)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1961</u> , to <u>Aug. 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 3, 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Katharine A. Chapman</u>				22b. ADDRESS		22c. DATE SIGNED <u>Aug 7, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>29711</u>				22d. ADDRESS		22e. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				25a. REC'D BY REGISTRAR <u>Aug 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>L. Snow</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be removed and retained by the funeral director.



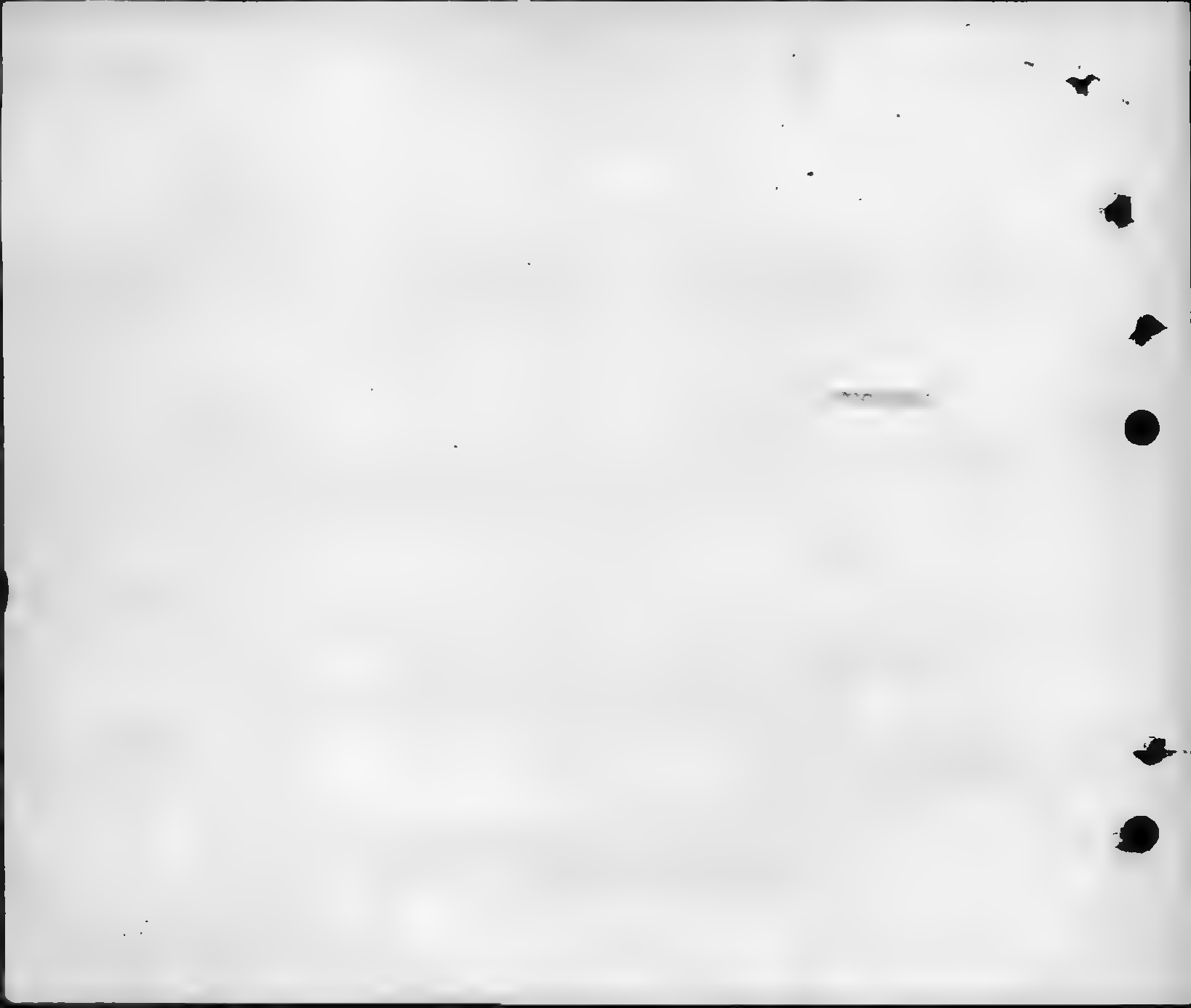
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VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8405
CERTIFICATE OF DEATH

09398

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5202 Worthington Drive		d. STREET ADDRESS 5202 Worthington Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Arthur Middle J Last Wadsworth		4 DATE OF DEATH Month August Day 21 Year 1961	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/8/67
9. AGE (in years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editor		10b KIND OF BUSINESS OR INDUSTRY Gov't Printing	
11 BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Alvin Wadsworth		14 MOTHER'S MAIDEN NAME (Unknown) Sherman	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO None	
17 INFORMANT Robert L. Wadsworth-son-same 2d		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS & MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 16 DAYS 15 YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from AUG. 3 19 61 to AUG. 21 19 61 that (I) (we) last saw the deceased alive on AUG. 17 19 61 and that death occurred at 8 AM , from the causes and on the date stated above			
22a SIGNATURE Philip R. James		22b DATE 8/21/61	
22c PHYSICIAN'S NAME (Type) Philip R. James		22d ADDRESS Washington Clinic, Washington D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 8/23/61	
23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d LOCATION (City, town, or county) (State) Washington, D. C.	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a REC'D BY REGISTRAR AUG 24 '61	
ADDRESS Bethesda, Maryland		25b REGISTRAR'S SIGNATURE Arthur S. James	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9406

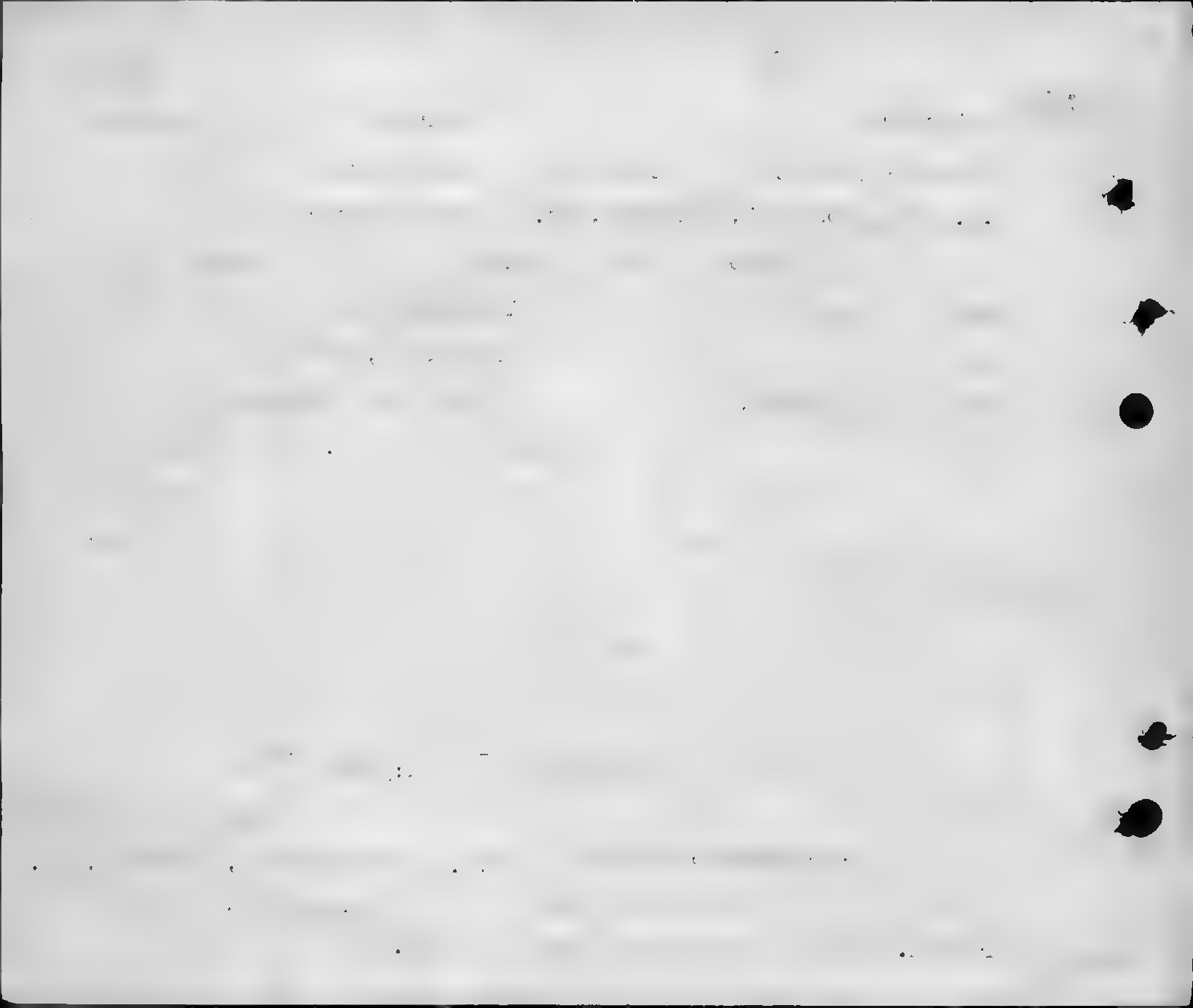
CERTIFICATE OF DEATH

09399

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5802 Winner Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sharon Diane WALKER 5. SEX Female 6. COLOR OR RACE Cauc 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH August 26 19 61 8. DATE OF BIRTH 11 November 53 9. AGE (In years last birthday) 7 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Walter WALKER 14. MOTHER'S MAIDEN NAME Bettye Jean MARTIN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No 16. SOCIAL SECURITY NO --- 17. INFORMANT (M) Mrs Bettye J. GAVIN same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Pneumonia DUE TO 587.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Fibrocystic Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Months 3 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-1-1961 to 8-26-1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8-26-1961 and that death occurred 2:30AM from the causes and on the date stated above			
22a. SIGNATURE M. C. O'Bannon M.D.		22b. DATE SIGNED 8-26-61	
22c. PHYSICIAN'S NAME (Type) M. C. O'BANNON, LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 29 August 1961	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town or county) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. NEWELL		25. REGISTRAR'S SIGNATURE Arthur L. Kraus	
25a. REC'D BY REGISTRAR DATE AUG 30 '61		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9407

09400

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Olney

c. LENGTH OF STAY (in days)

10 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Howard

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Fulton

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

George

Henry

Walter

4. DATE OF DEATH

Month

Day

Year

August 29 1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

Dec. 27, 1879

9. AGE (In years less birthday)

80 yrs

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (County & State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

George Walter

14. MOTHER'S MAIDEN NAME

Caroline (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute pyelonephritis

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

Nodular hyperplasia of prostate

(c)

Arteriosclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1961 to Aug. 29, 1961, that (I) (we) last saw the deceased alive on Aug. 28, 1961, and that death occurred at 6:58 PM, from the causes and on the date stated above.

22a. SIGNATURE

Charles S. Whitaker

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☒

STAFF PHYS. ☐

22b. DATE SIGNED

Aug. 29, 1961

22c. PHYSICIAN'S NAME (Type)

Charles S. Whitaker, M.D. Clarksville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

8/31/61

23c. NAME OF CEMETERY OR CREMATORY

St Pauls Lutheran

23d. LOCATION (City, town or county)

Fulton

(State)

Md

24. FUNERAL DIRECTOR'S SIGNATURE

De Witt Canaleman, Daniel, Md

ADDRESS

25a. REC'D BY REGISTRAR

DATE SEP 6 '61

25b. REGISTRAR'S SIGNATURE

Arthur L. Farris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

~~SECRET~~
FOI
HEAI

is necessary,
Director Page

TO DEPUT
please

VS. A
SM

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9408

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09401

1
R STAT
TH DEPT.

PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montg.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

701 Ritchie Ave.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First Roy

Middle Eugene

Last Walter

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7.14.31

4. DATE OF DEATH

Month August

Day 30

Year 19 61

9. AGE (in years last birthday)

30 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maintenance man

10b. KIND OF BUSINESS OR INDUSTRY

Wash. S S C

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Whitney Walker

14. MOTHER'S MAIDEN NAME

Beatrice C. Weaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes

Army

16. SOCIAL SECURITY NO.

215-24-0148

17. INFORMANT

Whitney Walter 701 Ritchie Ave, Sil. Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUPLICATE

(b)

DUPLICATE

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.T. ON GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Overcome by gas in manhole and fell in water

20c. TIME OF INJURY Month, Day, Year

10:15 a.m.

7/30

19 61

20d. INJURY OCCURRED

While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

street

20f. (City or town)

Bethesda

(County)

Montg.

(State)

Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M D

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8/30/61

EXAMINER'S NAME (Type)

Frank J. Broschart

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Sept 2, 1961

22c. NAME OF CEMETERY OR CREMATORY

George Washington Cemetery

22d. LOCATION (City, town, or country)

Prince Georges County

(State)

Md.

23. FUNERAL DIRECTOR

Arthur Walters, 254 Carroll St NW. DC

24. REC'D BY REGISTRAR

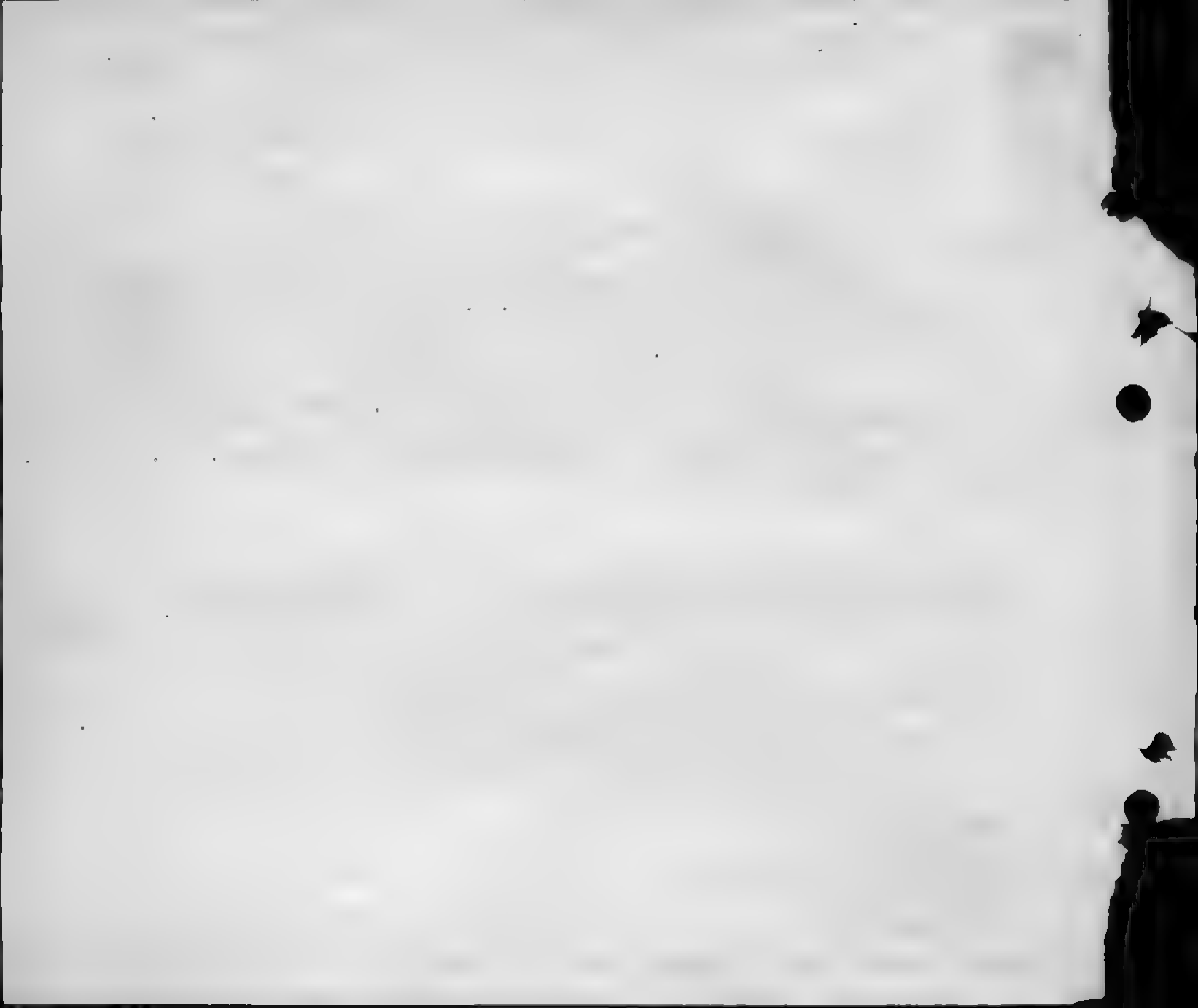
DATE SEP 5 '61

24b. REGISTRAR'S SIGNATURE

John S. Henth

MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any of pages 1, 2, and 3 to the funeral home, pages 4 and 5 will be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

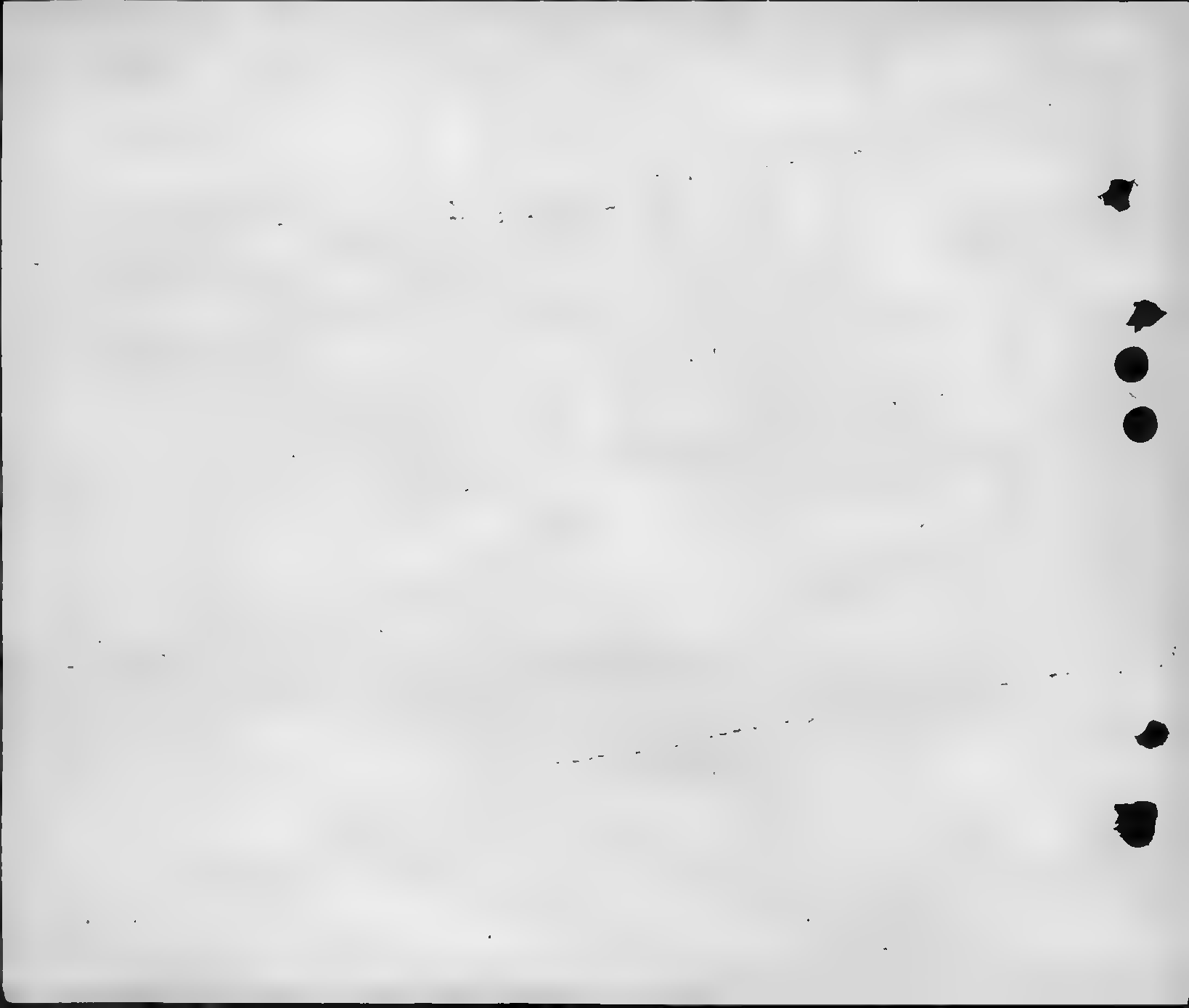
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in pencil in item 18. Give page 4 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09402

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b Do A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hosp - 2208 Parker Ave		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Elmer Merwin Ward		4. DATE OF DEATH Month 8 Day 27 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-01 19 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer, Nat'l Academy of Science		11. BIRTHPLACE (State or foreign country) Iowa	
13. FATHER'S NAME Reuben C. Ward		14. MOTHER'S MAIDEN NAME Lena Markesow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 229-25-7922	
17. INFORMANT Mrs Winona Ward wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO (b) MYOCARDIAL FIBROSIS AND INSUFFICIENCY DUE TO (c) OLD LEFT ANTERIOR DESCENDING CORONARY OCCLUSION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		INTERVAL BETWEEN ONSET AND DEATH HOURS	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brosch M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30, 1961	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Prince George's County Md.	
23. FUNERAL DIRECTOR WALTER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond C. Ziska		24b. REC'D BY REGISTRAR AUG 30 '61	
		24c. REGISTRAR'S SIGNATURE John S. Kraus	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park D.C.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington DC
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash SAN + Hosp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE DC
b. COUNTY St SE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1318 16th St SE
d. STREET ADDRESS 1318 16th St SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Middle Last
Clarence Leslie Ware
4. DATE OF DEATH
Month Day Year
8-19-61

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH
Month Day Year
11-16-02 158 yrs. 9. AGE (In years last birthday, yrs.)
10. IF UNDER 1 YEAR: Months Days 11. IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAKER
10b. KIND OF BUSINESS OR INDUSTRY Furniture Bus Maryland
11. BIRTHPLACE (State or foreign country) M-S.E
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Wm F Ware 14. MOTHER'S MAIDEN NAME Maudie Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO
16. SOCIAL SECURITY NO. 11-16-02 17. INFORMANT Smith W. Ware
Address 1318 16th St SE

18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO (b) History of Hypertension
Conditions, if any, which gave rise to immediate cause (c) History of Hypertension
DUE TO (e), stating the underlying cause (d) History of Hypertension
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) History of Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE OF DEATH (Primary or Contributing Cause of Death) History of Hypertension
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town, County, State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J Broschert M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J Broschert ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county) 1318 16th St SE DATE SIGNED 8-19-61
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Aug 22, 1961 22c. NAME OF CEMETERY OR CREMATORY Greenwood 22d. LOCATION (City, town or county) Southland, Md
23. FUNERAL DIRECTOR Lee Funeral Home ADDRESS 1318 16th St SE 24a. REC'D BY REG STRAR AUG 22 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Turner



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9411

CERTIFICATE OF DEATH

09404

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY N 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u> d. STREET ADDRESS <u>Kingsley Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Albert</u> Last <u>Watkins</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Aug. 12, 1866</u> 9. AGE (In years last birthday) <u>95</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Brick layer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Clyde . Watkins</u> 14. MOTHER'S MAIDEN NAME <u>Mandy Watkins</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Hospital Records</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>Bronchopneumonia, bilateral</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 10, 1960</u> to <u>August 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 31, 1961</u> , and that death occurred at <u>9:35 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>James P. Kerr</u> M.D. 22b. DATE SIGNED <u>8/31/61</u> 22c. PHYSICIAN'S NAME (Type) <u>James P. Kerr, M.D.</u> 22d. ADDRESS <u>Damascus, Maryland</u> 22e. REC'D BY REGISTRAR _____ 22f. REGISTRAR'S SIGNATURE _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-3-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u> 23d. LOCATION (City, town or county) <u>Purdum, Maryland</u> (State) _____ 24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u> DATE <u>SEP 5 '61</u> SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours of death. If any delay is necessary, the certificate should be executed within 72 hours of the date of death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9412 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 109405

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE MARYLAND
b. COUNTY District of Columbia
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 1217 G ST. S.E.

3. NAME OF DECEASED (Type or print)
First Luther Middle Ray Last Weakley

4. DATE OF DEATH
Month 8 Day 23 Year 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 11-23-00
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years (If UNDER 1 YEAR, If UNDER 24 HRS., test birthday) Months Days Hours Min. 60 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvation Army Worker 10b. KIND OF BUSINESS OR INDUSTRY Truck Driver - 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Weakley 14. MOTHER'S MAIDEN NAME Ada ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) No 16. SOCIAL SECURITY NO. 578-05-8567 17. INFORMANT Edna M. Weakley Address 1217 G St. S.E. Wash. D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO Coronary occlusion
(c) 420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: INTERVAL BETWEEN ONSET AND DEATH Sudden

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

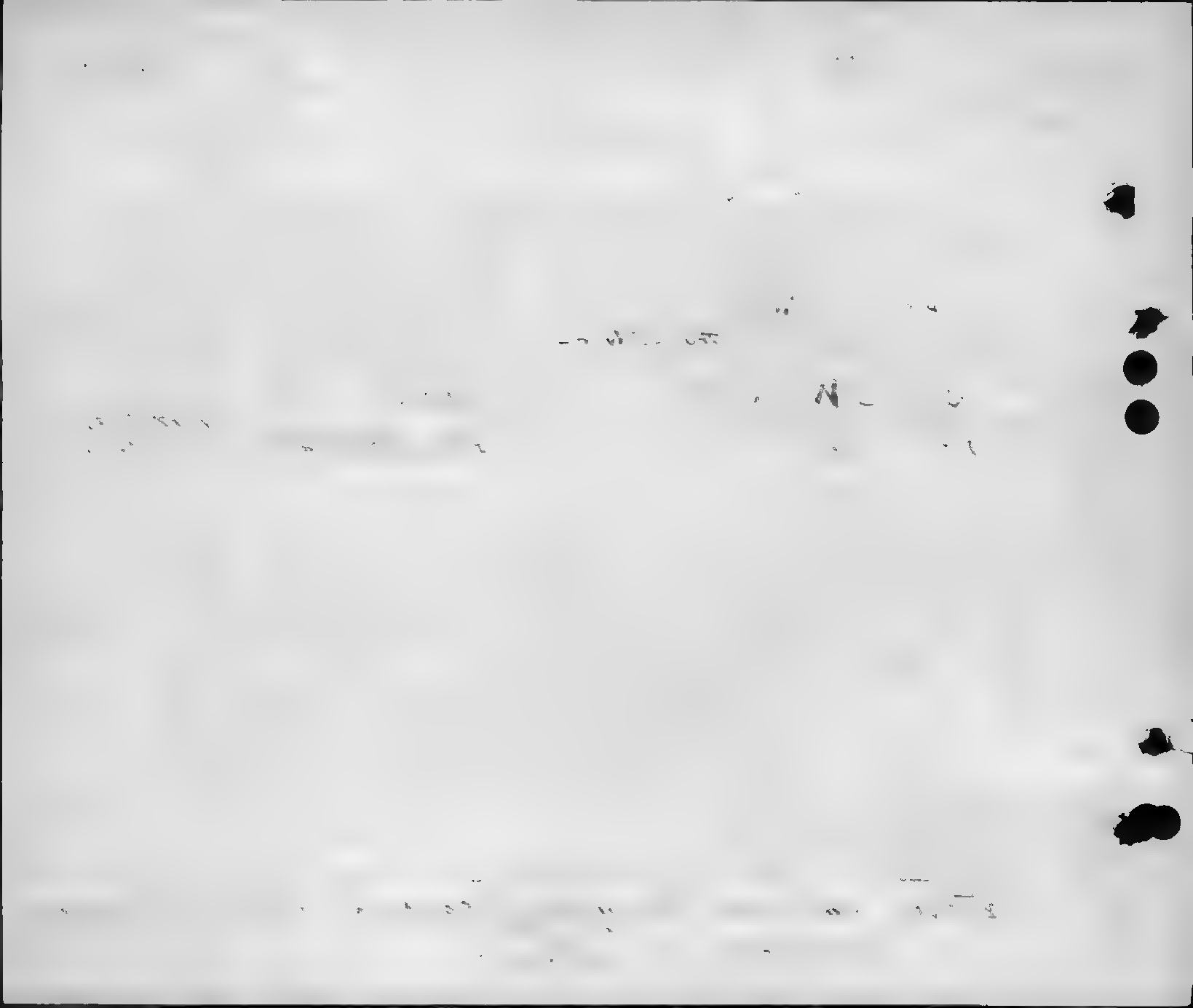
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 8-23-61

ACTUAL SIGNATURE Frank J. Broschert M.D. EXAMINER'S NAME (Type) FRANK J. BROSCHEART Address (Street, city, town, or county)

22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL 22b. DATE THEREOF Aug 26, 1961 22c. NAME OF CEMETERY OR CREMATORY Washington National 22d. LOCATION (City, town, or country) (State) Suitland, Maryland

23. FUNERAL DIRECTOR W. W. CHAMBERS CO ADDRESS 517 11th St SE Wash. D.C. 24a. REC'D BY REGISTRAR Aug 25 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kume



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 9 Film 3291 9/11/61 mh

9413

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence, home, or admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOBUBBAN</u>		d. STREET ADDRESS <u>3508 Farthing Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Infant Boy WERMTER</u>		4. DATE OF DEATH <u>Aug 30 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1961</u>
9. AGE (In years last birthday) <u>1</u>		10. IF UNDER 1 YEAR <u>1</u> IF UNDER 24 HRS <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RAYMOND WERMTER</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide BLAKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>770.5</u> DUE TO <u>Apnea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis</u> (c) <u>Prematurely Expiratory Effort</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> that I last saw the deceased alive on <u>19</u> and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Michael L. Sullivan</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-1-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARLINGTON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Hinder</u> ADDRESS <u>3831 - G St. Ave</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>
		DATE <u>SEP 7 '61</u>	

TO HOSPITAL: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed by the Medical Examiner, writing the word "pending" in pencil in item 15. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M. 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
9414 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09406										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY N 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>447 Southampton Drive</u> d. STREET ADDRESS <u>447 Southampton Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Albert Claude Whitlock</u>					4. DATE OF DEATH <u>August 27 1961</u>					
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Oct. 15, 1891</u> 69 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>					11. BIRTHPLACE (State or foreign country) <u>Roanoke, Virginia</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>Samuel Whitlock</u>					
14. MOTHER'S MAIDEN NAME <u>Fisher</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					
16. SOCIAL SECURITY NO. <u>unknown</u>					17. INFORMANT <u>wife</u> Address <u>447 Southampton Drive</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (a), stating the underlying cause last. DUE TO (c) <u>420.1</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Frank J. Broschelt</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHELT</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>8-27-61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <u>8-30-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL SUTHLAND</u>		22d. LOCATION (City, town, or country) (State) <u>MD</u>			
23. FUNERAL DIRECTOR <u>W.W. CHAMBERS & CO RIVERDALE MD</u>					24a. REC'D BY REGISTRAR <u>AUG 29 '61</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>										



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

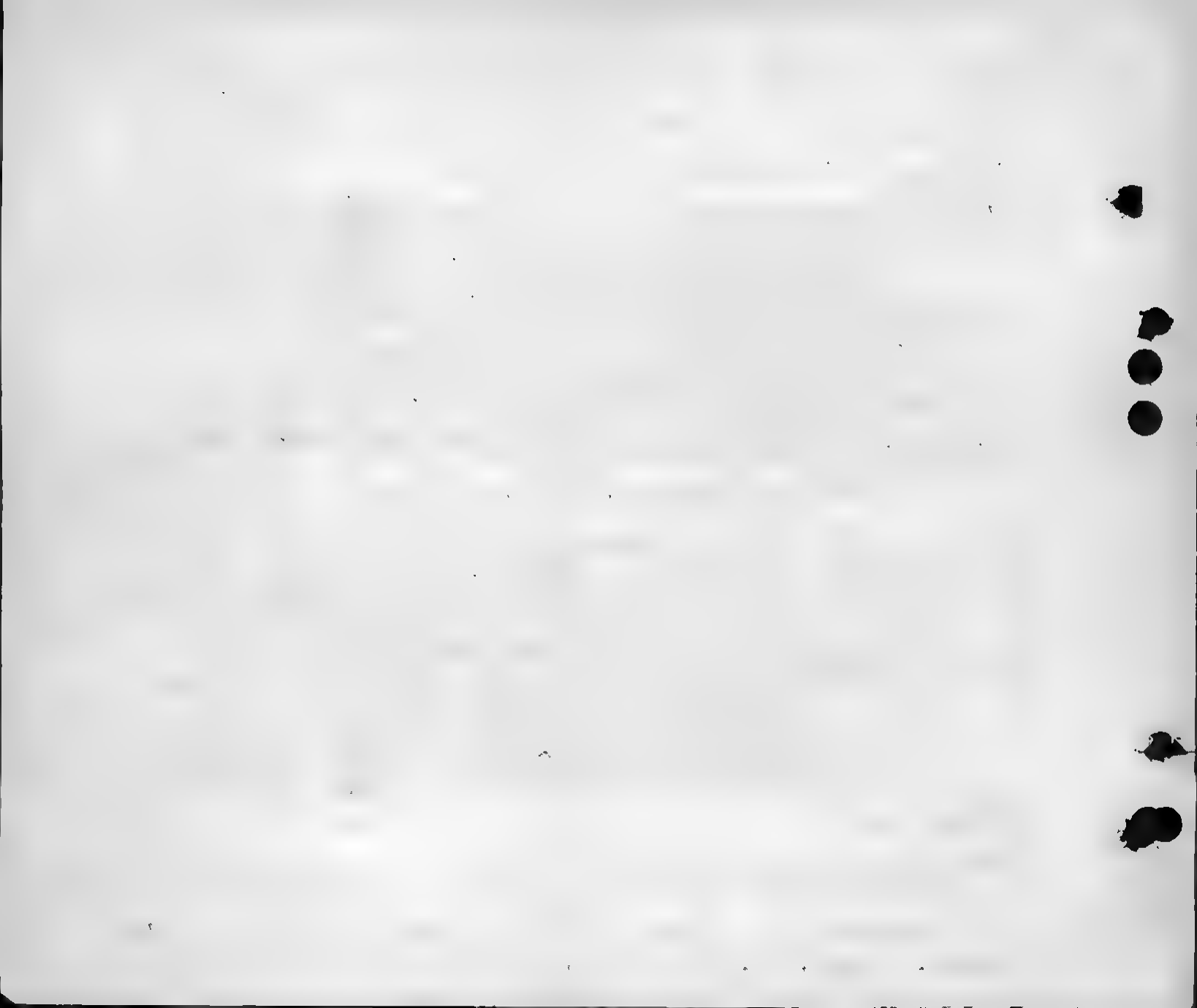
TO FUNERAL HOME: After this certificate has been signed by the attending physician, it should be completely filled in and should be filed with the funeral director. Pages 1 and 2 should be removed from the certificate. Page 3 should be detached for use as the burial-transit permit. Then please remove the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 09407

9415

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>15 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11,710 Georgia Avenue</i>		d. STREET ADDRESS <i>11710 Georgia Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Martha</i> Middle <i>CROSSAN</i> Last <i>Willard</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>23</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 21 1884</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR: Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Scotland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Cumming Halliday</i>		14. MOTHER'S MAIDEN NAME <i>M.S. Walker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Margaret M. Hahn</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 44 X DUE TO <i>Hypertensive Heart Disease</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>Emphysema</i> INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 29 1960</i> to <i>Aug 23 1961</i> , that I last saw the deceased alive on <i>Aug 23 1961</i> , and that death occurred at <i>2:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.		ADDRESS (Street, city or town, state) <i>918 Ellsworth Lane</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		<i>Silver Spring Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/28/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i> ADDRESS <i>8434 Georgia Avenue</i>		24a. REC'D BY REGISTRAR <i>Aug 25</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur J. Thoma</i>	
<i>Warner E. Pumphrey, Inc.</i> <i>Silver Spring, Maryland</i>		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

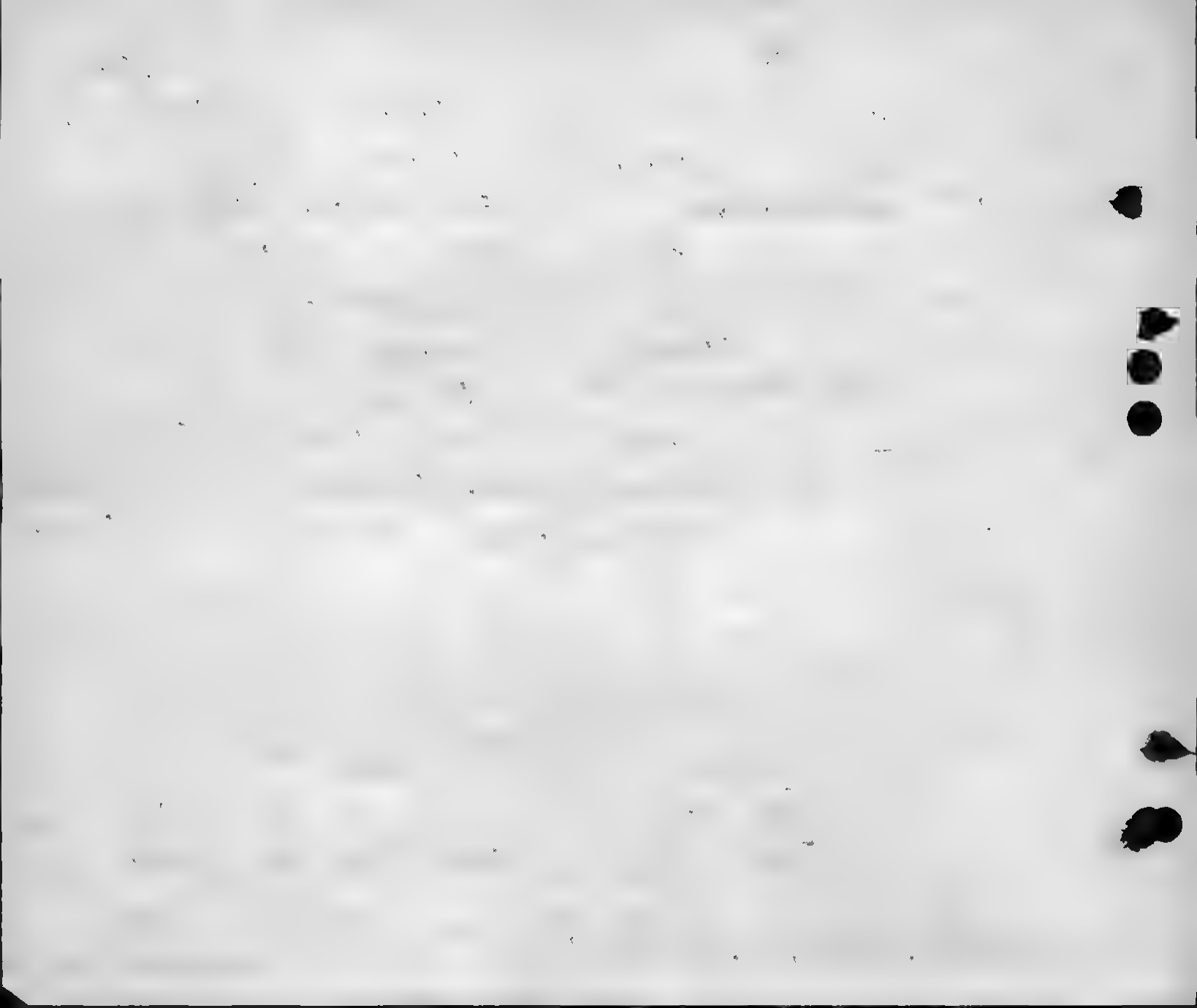
9415

CERTIFICATE OF DEATH

09408

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>Since 1952</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11,812 Valleywood Drive</u> e. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Henry</u> Last <u>Wilson</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Wheaton</u> d. STREET ADDRESS <u>11812 Valleywood Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> IF UNDER 24 HRS.: Hours <u>7</u> Min. <u>7</u> 13. FATHER'S NAME <u>William Henry Wilson</u> 14. MOTHER'S MAIDEN NAME <u>Helen Marbel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>William H. Wilson</u> Address <u>11510 Mapleview Dr. S.S. Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> (b) <u>Arteriosclerosis, General</u> (c) <u>5 weeks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>May 8, 1961</u> Hour a.m. <u>5:15 PM</u> p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 8, 1955</u> to <u>Aug 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 8, 1961</u> , and that death occurred at <u>5:15 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>John C. Yu</u> M.D. <u>Aug. 9, 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>John C. Yu</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>4912 Adrian St., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/12/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Montgomery Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. LeMay</u> 25a. REC'D BY REGISTRAR <u>AUG 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

TO HOSPITAL OR AT RESIDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9417

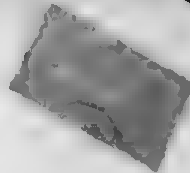
CERTIFICATE OF DEATH

09409

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN TB <u>2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u> <u>11901 Georgia Ave. S.S.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5021 Bradley Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nell N. Wilson</u>		4. DATE OF DEATH <u>8</u> <u>10</u> <u>1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 16, 1886</u>		9. AGE (In years) <u>74</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chattanooga, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Charles T. Neal</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bepue</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Thomas Wilson-son-</u>		Address <u>5315 Edgemoor Lane Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) a. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident +</u> b. DUE TO <u>Coronary heart disease due to</u> c. DUE TO <u>Generalized arteriosclerosis</u> Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>yes</u> PART I: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>weeks</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>None</u>							
20c. TIME OF INJURY Hour <u>a.m.</u> <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Simpsonville, Md.</u> (County) <u>Frederick</u> (State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>7-7-1961</u> , to <u>8-10-1961</u> , that (I) (we) last saw the deceased alive on <u>8-10-1961</u> , and that death occurred at <u>4:40</u> p.m. from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles R. Shultz, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-10-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles Shultz</u>		22d. ADDRESS <u>Simpsonville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			
23d. LOCATION (City, town or county) <u>Frederick, Maryland</u>		23e. STATE <u>Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u>		ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 14 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH**

Give nearest town)

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs, Md		c. LENGTH OF STAY IN lb 10 Days	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Alethia Nursing Home		e. STREET ADDRESS 7006 Wake Forest Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie Latimer Wilson		4. DATE OF DEATH Month Day Year August 12, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1875
9. AGE (In years last birthday) yrs 86		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John W Latimer		14. MOTHER'S MAIDEN NAME Eleanor Sheffield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Ralph Hodgson		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute congestive heart failure DUE TO (b) arterio-sclerotic cardiac DUE TO (c) vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1959 , to Aug 12, 1961 , that (I) (we) last saw the deceased alive on Aug 3, 1961 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above			
22a. SIGNATURE U.L. Etienne		22b. DATE SIGNED 8-12-61	
22c. PHYSICIAN'S NAME (Type) U.L. ETIENNE		22d. ADDRESS 4713 13th Ave S, S.W., Atlanta, Ga 30310	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 15, 1961	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State) Chicago Illinois
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE Aug 15, 1961	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9419
CERTIFICATE OF DEATH
09411

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 55 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Virginia b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsville d. STREET ADDRESS Route # 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roger First Marion Middle Worrell Last		4. DATE OF DEATH Month August Day 13 Year 19 61		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH December 19, 1940 9. AGE (In years last birthday) 20 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State, or foreign country) Ohio 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Blaine Worrell 14. MOTHER'S MAIDEN NAME Thelma Dee Edwards					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 1960 - 1961 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal cellulitis DUE TO (b) Nephrotic syndrome DUE TO (c) Staphylococcal cellulitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 591X INTERVAL BETWEEN ONSET AND DEATH 3 days 11 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 19, 1961 to August 13, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 13, 1961, and that death occurred at 6:40PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Richard Adler</i> 22c. PHYSICIAN'S NAME (Type) Richard Adler, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22b. DATE SIGNED 8/14/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/14/61		23c. NAME OF CEMETERY OR CREMATORY Mona Vista Mem. Gardens 23d. LOCATION (City, town or county) Carroll Count, Va.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i> 25a. REC'D BY REGISTRAR AUG 18 '61		ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE <i>Charles L. Hanna</i>			

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January 12, 1945

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9420

03412

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY in b 41 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Derwood d. STREET ADDRESS RFD #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth Felicia Zebuhr		4. DATE OF DEATH Month August Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1927
9. AGE (In years last birthday) 34 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry Tyson Bussard		14. MOTHER'S MAIDEN NAME Mary Catherine Lawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Medical Records	
17. INFORMATION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma (Generalized) (b) Metastasis to lungs, brain and lymph nodes (c) and both breasts. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 9, 1960 to Aug. 26, 1961 , that (I) (we) last saw the deceased alive on Aug. 25, 1961 , and that death occurred at 12 AM , from the causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED Aug. 26, 1961	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS Gaithersburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-29-61	
23c. NAME OF CEMETERY OR CREMATORY St. Rose		23d. LOCATION (City, town or county) (State) Gaithersburg, RFD Clapper, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg, Md.		25a. REC'D BY REGISTRAR AUG 29 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

TO HOSPITAL: The law requires that death certificates be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in the event, within 72 hours after death.

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McIntosh, William (Germans)
- McIntosh, Mary, born in
- and both parents.